A COMPARATIVE ANALYSIS OF MENTAL HEALTH PROFESSIONALS' DUTY TO WARN ACROSS THE UNITED STATES: THE NEED FOR CLEARLY DEFINED LAWS IN LIGHT OF RECENT MASS SHOOTINGS

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I. INTRODUCTION

The increased public attention on acts of mass violence has created substantial concern over the ability to prevent such violence.[1] Numerous political officials in recent years have attributed mental illness as the root cause of mass shootings, thus causing stigma to surround those with such conditions.[2] However, researchers suggest that while mental illness is undeniably a key risk factor in committing acts of mass violence, it is not the only factor involved.[3] In a recent study conducted in 2020, it was estimated that approximately two-thirds of public mass shooters who attacked from 1966 to 2019 displayed signs of mental illness.[4] Other recent studies suggest that roughly 25% of mass murderers have exhibited a mental illness.[5] Even still, politicians and media commentators often label mass shooters as mentally ill and turn to mental health professionals as a way to prevent these terrifying acts of violence.[6] Given the immeasurable impact of mass shootings, introducing laws that clearly define when a mental health professional is responsible for warning others of potential harm to the public could interrupt the process of violence and increase the mental health communities' effectiveness at managing those threats.[7]

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1 *Mental Health Professionals' Duty to Warn*, NAT'L CONF. STATE. LEG. (Mar. 6, 2022), https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx.

2 Jonathan M. Metzl et al., *Mental Illness, Mass Shootings, and the Future of Psychiatric Research into American Gun Violence*, 29 HARV. REV. PSYCHIATRY 81, 81 (2021).

3 Monir Ghaedi, *Mass shootings and mental illness: It's complicated*, DW (July 7, 2022), https://www.dw.com/en/mass-shootings-and-mental-illness-its-complicated/a-6238811.

4 Adam Lankford & Rebecca G. Cowan, *Has the Role of Mental Health Problems in Mass Shootings Been Significantly Underestimated?*, 7 J. THREAT ASSESSMENT AND MGMT. 135, 135 (2020).

5 Metzl et al., *supra* note 2, at 83.

6 *Id.* at 82.

7 *See generally* Mark A. Rothstein, *Tarasoff Duties After Newtown*, 42 J.L. MED. & ETHICS 104, 104 (2014).

Another study on mass shootings revealed the critical role mental health providers played with many of the perpetrators of mass violence.[8] The study examined public mass shootings in America from 1966 to 2019, finding that 67.7% of the mass shooters had a history of mental health concerns.[9] Moreover, 19% of mass shooters were hospitalized for psychiatric reasons, 25% participated in counseling, and 20% were prescribed psychotropic drugs.[10] This does not suggest that mental illnesses are the exclusive cause of mass shootings, as the vast majority of people with mental disorders are never violent.[11] Rather, these findings demonstrate the important role mental health providers play in preventing acts of mass violence and highlight the urgent need for state legislators to clearly define when a provider has the duty to warn others.[12]

In the aftermath of the reoccurring mass shootings in the United States, many public and elected officials have understandably tried to prevent such tragedies in the future.[13] Policymakers have focused on whether it is possible for mental health professionals to identify serious threats and intervene with mentally unstable individuals to prevent mass violence in the future.[14] This Note attempts to address this issue, specifically focusing on whether clearly defined duty-to-warn laws could help mental health professionals identify serious threats and intervene with mentally unstable individuals in time to prevent future tragedies.

This Note contributes to this discussion by assessing the varied jurisdictional approaches to duty-to-warn laws within the United States. Part I examines *Tarasoff v. Regents of University of California*, highlighting the California Supreme Court's reasoning and the conflicting duties imposed on therapists. Part II traces the judicial and legislative responses in the aftermath of *Tarasoff*, highlighting the shortcomings of the trends within *Tarasoff* laws. Part III critically assesses practical problems inherent in the implementation of the various duty-to-warn laws, arguing that ambiguity can arise because of the lack of clarity of the laws, the conflicting duties of confidentiality and protection of the public, and the inexact science of predicting violence. After reviewing the inconsistent and confusing laws on mental health professionals' duty to warn, Part IV proposes a clearly defined statute that

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8 *See* Jilian K. Peterson & James A. Densley, *The Violence Project: Database of Mass Shootings in the United States, 1966-2019* at 20-21 (2019), https://www.theviolenceproject.org/wp-content/uploads/2019/11/TVP-Mass-Shooter-Database-Report-Final-compressed.pdf.

9 *Id.* at 20.

10 *Id.* at 21.

11 *Id.* at 11-12.

12 Daniel C. Holland et al., *Tarasoff vs Threat: Considerations for Mental Health Providers Navigating Legal, Ethical and Practical Variables Associated with Preventing Mass Acts of Violence*, 23 INT'L J. EMERGENCY MENTAL HEALTH & HUM. RESILIENCE 86, 87 (2021).

13 Rothstein, *supra* note 7, at 104.

14 *Id.*

addresses the concerns of both the public and mental health professionals who legislators require to warn and protect third parties from patient violence. This solution seeks to clarify therapists' duties regarding the treatment of potentially violent patients while also serving the goal of preventing tragedies from occurring in the future.

II. *TARASOFF*: THE MENTAL HEALTH PROFESSIONAL'S DUTY TO WARN THIRD PERSONS OF PATIENT VIOLENCE

Mental health providers, in some situations, have been thought to dissuade violence and protect the public from harm through two distinct but related courses of action within the treatment setting.[15] First, successful treatment of a patient could address and treat underlying frustration, anxiety, and rage that could potentially erupt into violence.[16] Second, in situations where patient violence is imminent, mental health professionals are in a unique position to assess a patient's dangerousness to others and disclose any threats before any future harm occurs.[17] The second pathway was created in the landmark case of *Tarasoff v. Regents of University of California*, which was the "first case to find that a mental health professional may have a duty to protect others from possible harm by their patients."[18] The 1976 California Supreme Court decision fundamentally influenced modern principles relating to the duty-to-protect doctrine and the ethics of patient confidentiality within a therapeutic relationship.[19] While it has been more than forty years since the decision, the case remains relevant in many jurisdictions across the United States, with numerous courts relying on its reasoning as a basis for their decisions.[20]

A. *Tarasoff's* Creation of the Duty to Warn or Protect

Tarasoff arose from a tragic situation between two students at the University of California-Berkeley.[21] On October 27, 1969, Prosenjit Poddar, a 22-year-old male graduate student, killed Tatiana Tarasoff, an 18-year-old female undergraduate student.[22] Poddar and Tatiana met at a folk dance

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15 J. Thomas Sullivan, *Mass Shootings, Mental "Illness," and Tarasoff*, 82 U. PITT. L. REV. 685, 708 (2021).

16 *Id.*

17 *Id.*

18 Mary I. Wood, *Protective Privilege Versus Public Peril: How Illinois Has Failed to Balance Patient Confidentiality with the Mental Health Professional's Duty to Protect the Public*, 29 N. ILL. UNIV. L. REV. 571, 574 (2009).

19 *Id.* at 573-74.

20 *Id.* at 574.

21 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 339 (Cal. 1976).

22 *Id.*

hosted by the University of California-Berkeley International House.[23] After a brief and casual relationship, Tatiana broke off the relationship.[24] Subsequently, Poddar became depressed and sought treatment from a psychologist, Dr. Lawrence Moore, at Cowell Memorial Hospital.[25] Dr. Moore diagnosed Poddar with "paranoid schizophrenia, acute and severe."[26] During one of their sessions, Poddar informed Dr. Moore that he planned to kill an unnamed girl, readily identifiable as Tatiana, when she returned from summer vacation in Brazil.[27]

With the concurrence of two other doctors at Cowell Memorial Hospital, Dr. Moore decided that Poddar should be committed for observation at a psychiatric hospital.[28] Dr. Moore contacted campus police requesting assistance in securing Poddar's confinement.[29] The officers took Poddar into custody but ultimately determined he was rational and released him on his promise to stay away from Tatiana.[30] Subsequently, Dr. Powelson, director of the Department of Psychiatry at Cowell Memorial Hospital, requested the police to return Moore's letter for involuntary commitment.[31] Powelson then ordered that all of Dr. Moore's notes on Poddar be destroyed, and no action be taken to secure Poddar's involuntary commitment.[32] Shortly after Tatiana returned from Brazil, Poddar went to her brother's residence armed with a pellet gun and a kitchen knife.[33] When Tatiana refused to speak with him, Poddar repeatedly shot her with a pellet gun and fatally stabbed her in the front lawn.[34]

Tatiana's parents filed a wrongful death action against the university regents, the psychologist, supervising psychiatrists, and the police.[35] The plaintiffs asserted liability on two grounds: (1) the defendants' failure to warn plaintiffs of the impending danger and (2) their failure to bring about Poddar's confinement pursuant to the Lanterman-Petris-Short Act.[36] The California Supreme Court held that plaintiffs stated a cause of action against

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23 People v. Poddar, 518 P.2d 342, 344 (Cal. 1974).

24 *Id.*

25 *See id.*; *Tarasoff*, 551 P.2d at 341.

26 People v. Poddar, 518 P.2d 342, 345 (Cal. 1974).

27 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 341 (Cal. 1976).

28 *Id.*

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.*

33 People v. Poddar, 518 P.2d 342, 345 (Cal. 1974).

34 *Id.*

35 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 339-40 (Cal. 1976).

36 *Id.* The Lanterman-Petris-Short Act allows for mental health professionals to take a person into custody for involuntary treatment if, because of mental illness, he or she is likely to cause harm to self or others. *Understanding the Lanterman-Petris-Short (LPS) Act*, DISABILITY RTS. CAL. (Jan. 8, 2018), https://www.disabilityrightsca.org/publications/understanding-the-lanterman-petris-short-lps-act.

the psychiatrists at Cowell Memorial Hospital for failure to protect Tatiana from Poddar's foreseeable violence.[37] Although the court recognized that a person traditionally owed no duty to control the conduct of another in the absence of some "special relationship," the court found that a special relationship existed between a therapist and their patient.[38] The existence of a special relationship requires a therapist to take reasonable precautions to warn potential victims of danger after learning of a patient's intent to harm a third party.[39] The court further stated, "although plaintiffs' pleadings assert no special relation between Tatiana and defendant therapists, they establish as between Poddar and defendant therapists the special relation that arises between a patient and his doctor or psychotherapist."[40] It reasoned that the doctor-patient relationship was sufficient to support liability for failure to warn third persons of a patient's dangerousness because "by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient."[41]

The court highlighted the difficulties mental health professionals may experience when attempting to predict whether a patient would resort to violence.[42] It reconciled this concern by finding that a therapist need not "render a perfect performance."[43] Instead, a therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of (that professional specialty) under similar circumstances."[44]

The court also recognized that a therapist must be able to foresee from the patient's manifestations that the patient was likely to commit violent acts against a readily identifiable victim.[45] In applying its reasoning to the current case, Tatiana was a readily identifiable victim, which heightened the likelihood that she would suffer future harm, and warning Tatiana or her family could have prevented her murder.[46] The court concluded, "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,

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37 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 342 (Cal. 1976).
38 *Id. at 343.*
39 *Id.*
40 *Id.*
41 *Id. at 344.*
42 *Id.*
43 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976).
44 *Id.*
45 Sullivan, *supra* note 15, at 714.
46 *Id.*

he incurs an obligation to use reasonable care to protect the intended victim against such danger."[47]

While *Tarasoff* is recognized as creating the duty to warn, the decision's impact has proliferated widely decades later.[48] The court established that once a duty arises to warn or protect a potential victim, a therapist may be required to take reasonable and necessary action to protect the threatened individual.[49] Such steps that would satisfy this standard may include having the patient confined, notifying law enforcement, warning the intended victim, or taking other measures to protect the intended victim.[50] The court's broad language provides mental health practitioners the option of warning potential victims of a patient's threat.[51] It also allows them to seek other protections, such as involuntary hospitalization, which avoids breaking patient confidentiality.[52] However, requiring therapists to determine the meaning of "foreseeability" could distract from patient care and interfere with the critical decision-making of mental health providers.[53]

B. Conflicting Duties: Confidentiality and the Duty to Warn

Confidentiality is the basis of therapeutic trust in a medical and psychiatric relationship.[54] In *Tarasoff*, the California Supreme Court considered the difficulty in balancing patient trust in the therapeutic relationship with public protection.[55] The American Psychiatric Association (APA), in its amicus curiae brief, argued that a patient's trust in the psychotherapist is crucial in neutralizing violent-prone persons.[56] Moreover, the APA argued that the imposition of a duty to warn on psychotherapists undermines the therapeutic relationship and harms therapeutic effectiveness because it impairs the patient's ability to communicate freely.[57] According to the APA, the imposition of a duty to warn would result in overprediction of violence, numerous breaches of confidentiality, and premature termination

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47 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976).

48 Rothstein, *supra* note 7, at 106.

49 *Id*.

50 *Id*.

51 *Tarasoff*, 551 P.2d at 346.

52 Sullivan, *supra* note 15, at 716.

53 Robert I. Simon, *The Myth of "Imminent" Violence in Psychiatry and The Law*, 75 U. CIN. L. REV. 632, 643 (2006) (stating "'Foreseeability' and 'near future' are legal fictions as applied to clinical assessment of violence toward one-self or others, [which] is indicative of the imperfect fit between psychiatry and the law.").

54 Wood, *supra* note 18, at 577.

55 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 346 (Cal. 1976).

56 Brief for American Psychiatric Association et al. as Amici Curiae Supporting Respondents, Tarasoff v. Regents of Univ. of Cal., 551 P. 2d 334 (Cal. 1976) (No. 23042), at 26-27.

57 *Id*. at 26.

of therapy, which would increase the patient's danger to society.[58] When weighing the public interest in supporting effective treatment of mental illness and protecting patients' rights to privacy against the public interest in safety from violent assault, the California Supreme Court found that the uncertain and conjectural character of the alleged damage to the patient did not overcome the possible peril to the victim's life.[59] Moreover, the court held that "professional inaccuracy in predicting violence cannot negate the therapist's duty to protect the threatened victim."[60] The court justified its holding by stating, "[t]he risk that unnecessary warnings may be given is a reasonable price to pay for the lives of possible victims that may be saved."[61]

Free and open communication between patient and provider was one of the main concerns set forth by the *Tarasoff* defendants regarding the patient's potential damage from a breach of confidentiality.[62] However, the court rejected the defendants' argument that the possibility of issuing warnings based on information disclosed in psychotherapy would undermine the free and open communications essential to effective therapy.[63] Instead, the court found that "the public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others."[64] In other words, patient-confidentiality must be overcome when disclosure is necessary to avoid harm to another.[65] The court famously concluded, "the protective privilege ends where the public peril begins."[66]

Conversely, in his dissent, Justice Clark took the opposite approach to the issue of confidentiality.[67] He asserted that confidentiality was the cornerstone of effective treatment of mentally ill patients and that if confidentiality were undermined, the therapeutic relationship would be irreparably destroyed.[68] Justice Clark offered a threefold explanation against imposing a duty on mental health professionals to disclose patient threats to potential victims.[69] First, people will avoid seeking mental health treatment if they believe their medical information will be shared with outsiders.[70] Second, confidentiality promotes full disclosure and allows patients to

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58 *Id.* at 11.
59 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 346 (Cal. 1976).
60 *Id.*
61 *Id.*
62 *Id.* at 347.
63 *Id.*
64 *Id.*
65 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 347 (Cal. 1976).
66 *Id.*
67 *See id.* at 354-62 (Clark, J., dissenting) (arguing that patient confidentiality is of utmost importance and that the duty to warn would irreparably destroy the therapeutic relationship).
68 *Id.* at 354-55 (Clark, J., dissenting).
69 *See id.* at 354-62 (Clark, J., dissenting).
70 *Id.* at 359 (Cal. 1976) (Clark, J., dissenting).

provide complete and accurate information, which is essential to treatment.[71] Finally, confidentiality builds trust by providing assurances that patient communications are confidential.[72] Justice Clark's concern about the majority's encroachment on patient-confidentiality has remained consistent with professional apprehensions over the decision's imposition of a duty to warn or protect third persons from dangerous patients.[73]

Justice Clark's concerns about *Tarasoff*'s effect on mental health treatment are shared by many.[74] One major concern is grounded in the idea that psychiatric care still carries a great deal of social stigma.[75] Because a sense of shame is associated with a psychiatric disorder, "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."[76] Without the assurance of confidentiality, individuals who need mental health treatment may be deterred from seeking necessary care.[77] Unnecessary warnings and fruitless breaches of trust in the therapeutic setting could have potentially harmful consequences, such as suppressing disclosure completely.[78]

Additionally, the duty to protect society from violent patients has seemingly complicated the treatment of mentally ill patients and possibly impaired therapeutic effectiveness because of the therapist's fear of legal repercussions that could result from failure to disclose a patient's threat.[79] According to Mary I. Wood, the confusion surrounding a mental health practitioner's duty to warn "can impair a therapist's ability to effectively treat a patient when the focus shifts from the patient's problems to the therapist's duty and potential liability."[80] Given that public protection is one of the few instances that a provider's obligation of confidentiality may be overridden, [81] clarifying mental health providers' duty to warn could offer unique prospects for preventing violent behavior in the future while still protecting trust within the therapeutic relationship. This concern is shared not only by the mental health community but also by courts across the United States.[82]

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71 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 359 (Cal. 1976) (Clark, J., dissenting).
72 *Id.* at 359-60 (Clark, J., dissenting).
73 Sullivan, *supra* note 15, at 717.
74 *See e.g.*, Wood, *supra* note 18, at 579.
75 *Id.* at 578.
76 *Id.*
77 *Id.* at 579.
78 *Id.*
79 *See generally* Anna Whites & Matthew W. Wolfe, *The Provider's Duty to Protect Patients and Third Parties*, 12 J. HEALTH & LIFE SCI. L. 1, 5 (2019).
80 Wood, *supra* note 18, at 580.
81 Whites & Wolfe, *supra* note 79, at 5.
82 Sullivan, *supra* note 15, at 717.

III. THE CONFUSING AFTERMATH: LEGISLATIVE AND JUDICIAL RESPONSES TO *TARASOFF*

Since the *Tarasoff* decision, most states have enacted statutes that address the circumstances in which a practitioner has a duty to warn third parties of potentially violent patients.[83] As the notion of a duty to warn crept across the United States, it created critical variations among the states.[84] In Professor Mark Rothstein's examination of the differing legislative responses to *Tarasoff*, he notes that there is no single duty to warn, but rather fifty-one jurisdiction-specific duties.[85] According to Rothstein, as of 2014, twenty-nine states have imposed a mandatory duty to report serious threats, sixteen states and the District of Columbia implemented permissive duty-to-warn laws, four states had yet to impose any duty to report, and Georgia stood alone with its own unique law. [86] Since 2014, two states that previously had no duty to report, Nevada and Maine, adopted mandatory duty-to-warn statutes.[87]

There are several other variations among state statutes.[88] For example, some state laws differ on the circumstances when warnings or other protective measures are appropriate.[89] Others vary on the individuals or entities that must be protected.[90] Additionally, some states grant immunity from liability if the mental health professional complies with certain statutory requirements.[91]

While many scholars categorize jurisdictional responses to *Tarasoff* differently, it is clear that various positions have emerged as each state has wrestled with the implications of the duty to warn.[92] In a review of *Tarasoff*

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83 Wood, *supra* note 18, at 584.

84 *See* Paul B. Herbert & Kathryn A. Young, *Tarasoff at Twenty-Five*, 30 J. AM. ACAD. PSYCHIATRY L. 275, 276-80 (2002).

85 Rothstein, *supra* note 7, at 106.

86 *Id.* Since 2014, two states that previously had no duty to report, Nevada and Maine, have adopted mandatory duty to warn statutes. *See* ME. REV. STAT. ANN. tit. 32 § 7007 (2022); *see also* NEV. REV. STAT. ANN. § 629.550 (2021).

87 *See* ME. REV. STAT. ANN. tit. 32 §7007 (2022); *see also* NEV. REV. STAT. ANN. § 629.550 (2021).

88 Rothstein, *supra* note 7, at 106; *see e.g.*, NEB. REV. STAT. ANN. § 38-2137; LA. STAT. ANN §9:2800.2; COLO. REV. STATE. ANN. §13-21-117; CAL. CIV. CODE. ANN. § 43.92; IND. CODE §34-30-16-1.

89 Rothstein, *supra* note 7, at 106; *see e.g.*, DEL. CODE ANN. TIT. 16, § 5402; LA. STAT. ANN §9:2800.2 (providing that Delaware requires there to be an explicit and imminent threat to kill or seriously injure a clearly identified victim for the duty to warn to arise. Whereas Louisiana's duty to warn law requires there to be a threat of physical violence, deemed significant by the treating provider, against a clearly identified victim, and there to be apparent intent and ability to carry out such threat).

90 Rothstein, *supra* note 7, at 106; *see e.g.*, DEL. CODE ANN. TIT. 16, § 540; 405 ILL. COMP. STAT. ANN 5/6-1003; FLA. STAT. ANN. § 456.059.

91 Rothstein, *supra* note 7, at 106.

92 *See generally* Taylor Gamm, *Beyond the Symptoms: Finding the Root Cause of the Chaotic Tarasoff Laws*, 86 U. CIN. L. REV. 823, 835 (2018); Wood, *supra* note 18, at 585 (categorizing jurisdictional

statutes, which tracked the variations of duty-to-warn laws in the United States, Paul Herbert and Kathryn Young found that "the variety of duty-to-warn laws across the nation—with no two states agreeing precisely on a common approach—is virtually unprecedented for any pervasive legal doctrine."[93] Moreover, Herbert and Young concluded that "confusion is an inevitable product, and confusing law is inefficient at best, and often harmful."[94] Despite the *Tarasoff* court's attempt to clearly define the duty to warn and protect, the court's guidance did not assist other states in writing clear and understandable statutes and did not define the duty in a way that was intelligible and useful to mental health professionals.[95]

To obtain a better understanding of the trends that have developed across the nation since *Tarasoff*, Part II of this Note intends to subdivide the differing jurisdictional approaches into five broad categories: (1) clear affirmative duty to warn, (2) permissive duty to warn, (3) immunity for failure to warn except for in limited circumstances, (4) the hybrid approach, and (5) no-duty-to-warn jurisdictions.

A. Clear Affirmative Duty-to-Warn Statutes

In states that impose a clear affirmative duty to warn, also known as a mandatory duty to warn, mental health professionals are mandated by state law to disclose patients' threats to third parties.[96] However, these providers are protected from legal action by patients whose confidentiality is breached.[97] In states that establish a clear affirmative duty to warn, there is minimal uncertainty about the presence of a duty.[98] For example, Idaho's statute imposes a clear affirmative duty on mental health professionals to warn third persons of a patient's threat.[99] The statute uses clear, unambiguous language, such as "a mental health professional has a duty to warn," which leaves little room to doubt the existence of a duty.[100] The Idaho statute provides that a mental health professional has a duty to warn a third person if "a patient has communicated to the mental health professional an explicit

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variation in four general categories: "those that explicitly establish a duty, those that prohibit liability except under particular circumstances, those that seem to permit but not require disclosure, and those that take other approaches."); Sullivan, *supra* note 15, at 752 (analyzing variations of state law by diving approaches into mandatory duty to warn or protect, permissive approach to the duty to warn or protect, a hybrid approach to warning, and the Arkansas immunity model).

93 Herbert & Young, *supra* note 84, at 280.

94 *Id.*

95 Wood, at *supra* note 18, at 584.

96 Chinh, *Understanding Duty to Warn*, SW TO SW (July 30, 2017), https://swtosw.com/2017/07/30/understanding-duty-to-warn/.

97 *Id.*

98 Wood, at *supra* note 18, at 584.

99 IDAHO CODE ANN. §6-1902 (1991).

100 *Id.*

threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat."[101]

Although Idaho's statute clearly establishes a duty to warn, it fails to provide the protection necessary to prevent future acts of violence.[102] This is primarily because of its requirement for "imminent" physical harm or death.[103] The imminence requirement is an extremely high bar to meet for disclosures.[104] For example, in *Garner v. Stone*,[105] a police officer disclosed to his psychologist that he had a vision of killing his captain and thought about killing eight to ten others, including the police chief and county commissioner.[106] The psychologist decided these threats were serious and reported them to the police officer's superiors.[107] The psychologist indicated that he "did not believe the threats to be imminent but considered them to be very serious."[108] The police officer sued the psychologist for violating the physician-patient privilege after the psychologist warned his superiors.[109] Ultimately, a six-person jury in a Georgia Superior Court found in favor of the former police officer.[110] As seen in this case, imminence implies immediacy, and often fails to take into account that a patient may make credible threats or indicate dangerousness without expressly stating that they intend to take immediate action to carry out those threats.[111] Although the requirement for imminent physical harm or death is likely intended to limit

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101 *Id.*

102 *See* Rothstein, *supra* note 7, at 107 (stating the imminence standard sets the bar too high by limiting disclosures to threats that indicates immediacy and fails to consider that a patient may make credible threats and indicate dangerousness without expressly stating that he or she intends to take immediate action to carry out those threats).

103 *See* Rothstein, *supra* note 7, at 107 (showing many states use "imminent" or "immediate."); *see also* Emerich v. Phila. Ctr. for Human Dev., Inc., 720 A.2d 1032, 1039-40 (Pa. 1998) ("immediate, known and serious risk"); COLO. REV. STAT. § 13-21-117 (2008) ("imminent"); DEL. CODE. ANN. tit. 16, § 5402(a)(1) (2003) ("imminent"); IDAHO CODE ANN. § 6-1902 (2004) ("imminent"); IND. CODE § 34-30-16-1 (1999) ("imminent"); N.J. STAT. ANN. § 2A:62A-16 (2000) ("imminent"); OHIO REV. CODE ANN. § 2305.51(B) (2018) ("imminent").

104 Rothstein, *supra* note 7, at 107.

105 Garner v. Stone, No. 97A-320250-1 (Ga., DeKalb County Super. Ct. Dec. 16, 1999).

106 William F. Doverspike, *The So-Called Duty to Warn: Protecting the Public versus Protecting the Patient*, 61 GA. PSYCH. 20, 26 (2007), available at http://drwilliamdoverspike.com/files/how_to_manage_the_duty_to_protect.pdf.

107 *Id.*

108 *Id.* at 27.

109 *Id.* at 26.

110 *Id.*

111 Rothstein, *supra* note 7, at 107.

the obligations of mental health professionals,[112] "it is equally likely to result in confusion and a reluctance to take action to prevent harms."[113]

A general commonality among these jurisdictions is that a therapist must warn "either the victim or law enforcement after a patient makes an explicit and specific threat of physical harm."[114] However, some jurisdictions, such as Indiana, Maryland, Massachusetts, and New Jersey, require a psychotherapist not only to warn of explicit threats by the patient but also require a warning if an assessment of the patient's actions or the circumstances evidences a threat to a third party.[115]

B. Immunity for Failure to Warn or Protect Except For In Limited Circumstances

Within the mandatory duty-to-warn category is a subcategory in which jurisdictions provide immunity for failure to warn or protect except in limited circumstances.[116] In these jurisdictions, a mandatory duty is imposed on mental health practitioners only when narrow and specified events occur within the therapeutic setting.[117] In the absence of such circumstances, the statutes provide immunity to the therapist for failure to disclose a patient's potential threat.[118] For example, laws within this category generally state, "[a] mental health practitioner . . . is not liable for failing to warn of a patient's threatened violent behavior unless . . ."[119] or "no cause of action shall arise against . . . a psychotherapist . . . for failing to protect . . . except . . ."[120]

However, laws that provide immunity to psychotherapists for failure to warn, except in limited circumstances, often require clarification.[121] For example, Colorado's statute provides that a mental health professional is not liable for failure to warn or protect unless a specific set of circumstances are

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112 *See, e.g.*, McCarty v. Kaiser-Hill Co., L.L.C., 15 P.3d 1122, 1124 (Colo. App. 2000); Fredericks v. Jonsson, 609 F.3d 1096, 1099 (10th Cir. 2010) (discussing that a mental health provider only has a duty to warn when a patient communicates a serious threat of imminent violence. If there is no evidence of a serious threat of imminent violence, then a provider will not be held liable for failure to warn).

113 Rothstein, *supra* note 7, at 107.

114 Taylor Gamm, *Beyond the Symptoms: Finding the Root Cause of the Chaotic Tarasoff Laws*, 86 U. CIN. L. REV. 823, 836 (2018).

115 Herbert & Young, *supra* note 84, at 278.

116 Wood, *supra* note 18, at 571.

117 *See, e.g.*, NEB. REV. STAT. § 38-2137 (2022); LA. STAT. ANN. § 9:2800.2 (2022); DEL. CODE ANN. tit. 16, § 5402 (2018); COLO. REV. STAT. § 13-21-117 (2022); ARK. CODE ANN. § 20-45-202 (2013); CAL. CIV. CODE § 43.92 (2013); IND. CODE. § 34-30-16-1 (1998).

118 *See, e.g.*, *id.*

119 NEB. REV. STAT. § 38-2137 (2022).

120 CAL. CIV. CODE § 43.92 (2013).

121 *See, e.g.*, COLO. REV. STAT. § 13-21-117 (2022).

met.[122] While Colorado's attempt to shield therapists from liability is admirable, its lack of clarity makes it difficult for mental health providers to appreciate when such a duty arises.[123] Colorado statute provides in part:

> A mental health provider is not liable for damages in any civil action for failure to warn or protect a specific person or persons, including those identifiable by their association with a specific location or entity, against the violent behavior of a person receiving treatment from the mental health provider, and any such mental health provider must not be held civilly liable for failure to predict such violent behavior except where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity.[124]

The Colorado statute is chaotic and even incoherent at times.[125] The statute seemingly protects mental health providers from "failure to warn or protect a specific person or persons," while also imposing a duty on those mental health professionals for failure to disclose "a serious threat of imminent physical violence against a specific person or persons."[126] With the difficulties involving imminence and practical issues of applying the imminence standard within the treatment setting, therapists are unlikely to recognize when liability begins and immunity ends.[127] However, one notable aspect of Colorado's statute is its extension of the duty to warn to cover persons that are "identifiable by their association with a specific location or entity."[128] Since mass shootings have increasingly targeted different venues in recent years, such as churches, synagogues, grocery stores, and movie theaters, including language that encompasses specific locations within duty-to-warn statutes could help prevent future acts of mass violence.[129]

Another distinguishing factor of this type of duty-to-warn statute is the communication of a serious threat of imminent physical violence.[130] Under Colorado law, a patient must communicate a serious threat of physical violence to a mental health professional in order for the duty to warn to be

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122 *Id.*
123 *Id.*
124 *Id.*
125 *Id.*
126 *Id.*
127 COLO. REV. STAT. § 13-21-117 (2022).
128 *Id.*
129 Faith Karimi, *Mass shooters are increasingly attacking 'soft targets' such as supermarkets. Experts say securing them will be difficult*, CNN (May 20, 2022, 7:10 AM), https://www.cnn.com/2022/05/20/us/mass-shooters-soft-targets-challenges-cec/index.html.
130 *See Duty to Protect: Roles and Responsibilities for Psychologists*, APA PRAC. ORG. 1, 2 (2013), https://www.apaservices.org/practice/good-practice/duty-to-protect.pdf.

triggered.[131] In *Fredericks v. Jonsson*, a patient previously expressed to a psychologist that he used to have "frequent violent fantasies" involving members of the plaintiff's family, but that he no longer experienced those violent thoughts.[132] The psychologist did not convey any warnings to the patient's probation officer or the plaintiffs.[133] Two weeks after the examination, the patient drove to the plaintiffs' home and broke a window in an attempt to break in.[134] The plaintiffs brought an action against the psychologist for negligent failure to warn, arguing that the psychologist had a duty to warn them because any reasonable psychologist in her position would have known from the patient's history that he posed a serious risk of violence to the plaintiffs.[135] The court rejected this argument because Colorado's duty-to-warn statute requires that the threat be "communicated" to the mental health provider.[136] The court interpreted this to mean that a mental health provider has a duty to warn only when the patient himself predicts his violent behavior by communicating or expressing his threat to the mental health provider.[137] Although the court found that the patient's actions may have led a reasonable psychologist to believe that the patient was a threat to the plaintiffs, it was unwilling to hold the psychologist liable because there was no evidence that the patient communicated "a serious threat of imminent physical violence against a specific person or persons."[138]

The requirement of a communication of a specific threat of imminent physical violence is underinclusive and brings to light issues with "specificity."[139] For example, in *Riley v. United Health Care of Hardin, Inc.*, a male patient with a propensity towards violence never communicated a specific threat toward anyone in his family.[140] However, his hospital records indicated that "he has certainly thought about . . . " hitting his mother, and that "problems related to increased irritability and anger have become more and more evident with his mother."[141] Moreover, the patient told hospital staff that if he was forced to return to his mother's home, "he might do something he would regret later."[142] Five days after the patient's release, he

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131 Fredericks v. Jonsson, 609 F.3d 1096, 1097 (10th Cir. 2010).

132 *Id.* at 1098.

133 *Id.*

134 *Id.*

135 *Id.* at 1105.

136 *Id.*

137 Fredericks v. Jonsson, 609 F.3d 1096, 1105 (10th Cir. 2010).

138 *Id.* at 1106.

139 *See* A.G. Harmon, *Back from Wonderland: A Linguistic Approach to Duties Arising from Threats of Physical Violence*, 37 CAP. U. L. REV. 27, 61 (2008) ("A good portion of duty to warn cases . . . [require] specificity of the intended victim. If the threat/pledge is not against either a clearly or reasonably identifiable victim, the duty does not arise.").

140 Riley v. United Health Care of Hardin, Inc., No. 97-5860, 1998 WL 5d8733, at *2 (6th Cir. 1998).

141 *Id.*

142 *Id.*

killed his mother.[143] The hospital was not liable for failure to warn because the patient never communicated any threat of a specific act of violence to the hospital staff, nor did he articulate a direct threat of physical harm against his mother.[144] The court held that the statement that he "might do something he might regret later" was not sufficient to impose a duty to warn on the hospital because the statement did not specify the intended victim or a violent act.[145] In states requiring a communication of a specific threat of imminent physical violence, many potential victims are left without warning of a patient's propensity towards violence.[146] While a patient's prediction of their own violence is a clear sign that another person is in danger, many patients are unlikely to specifically state "I am going to kill X," which exposes many potential victims to probable violence without warning.[147]

However, Indiana takes a different approach to the duty to warn.[148] Under Indiana law, a mental health provider has no duty to "predict" or "warn or take precautions to protect from" a patient's violent behavior unless the patient "has communicated to the provider of mental health services an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims" or the patient "evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or other means to cause serious personal injury or death to others."[149] Indiana courts have interpreted this to mean that a mental health provider's duty to warn arises when a patient makes an actual threat of physical violence or the totality of the circumstances indicate that the patient is an imminent danger to others.[150]

The Indiana Court of Appeals, in *Coplan v. Miller*, held that determining whether a patient posed "imminent danger" required a consideration of the entire treatment period, rather than a consideration of each treatment separately.[151] In *Coplan v. Miller*, a patient, Zachary Miller, killed his grandfather after a month of erratic behavior and six trips to the emergency room at Community Howard Regional Health in Kokomo, Indiana for mental health issues.[152] Miller was taken to the hospital on multiple occasions because of threats made to his mother and grandfather.[153]

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143 *Id.*

144 *Id.* at *4.

145 *Id.*

146 *See e.g.*, Riley v. United Health Care of Hardin, Inc., No. 97-5860, 1998 WL 5d8733, at *4 (6th Cir. 1998).

147 *See e.g.*, Coplan v. Miller, 179 N.E.3d 1006 (Ind. Ct. App. 2021).

148 *See* IND. CODE ANN. § 34-30-16-1 (1998).

149 IND. CODE ANN. § 34-30-16-1 (1998).

150 *See e.g.*, *Coplan*, 179 N.E.3d at 1012-13.

151 *Id.* at 1013.

152 *Id.* at 1008-09.

153 Coplan v. Miller, 179 N.E.3d 1006, 1008-09 (Ind. Ct. App. 2021).

On one of the occasions, Miller was brought to the hospital by the police after his grandfather reported that Miller had kicked him and threatened to kill him.[154] The hospital subsequently determined that Miller presented a "psychiatric problem" and a "homicide risk."[155] On another occasion, Miller was brought to the hospital by police officers after he threatened to kill his mother, kicked his grandfather a second time, and killed the family dog.[156] Each time Miller went to the hospital, he was discharged with instructions to follow up with behavior health.[157] On his final trip to the emergency room, Miller was acting "anxious," "paranoid," and "agitated" and asked to be admitted to the hospital.[158] The doctors determined that "inpatient treatment was not medically necessary" and ordered the patient to be discharged.[159] Within hours of his release, the patient went to his grandfather's home and brutally attacked him.[160] The patient hit his grandfather with a frying pan, stomped on his head, choked him, and cut his wrist with a steak knife.[161] His grandfather succumbed to his injuries two days later.[162]

The defendants argued that the patient's actions during the month before the attack were insufficient to trigger the duty to warn because he never communicated an actual threat against his grandfather, and the patient did not manifest conduct indicating that he was seriously going harm another person.[163] The court agreed that the actual threat prong was not met because although the patient acknowledged making earlier threats against his grandfather, this was not the same as saying "Doctor, I'm going to kill [my grandfather]."[164] However, the court found that when determining the imminent-danger prong, a patient's conduct should be considered as a whole, including consideration of a patient's "historical" or "prior" conduct.[165] The court concluded that the patient's conduct on the day of the murder should not be considered in a vacuum, and that the court could not ignore "all the disturbing things he said and did over the previous thirty days."[166] Viewing the totality of the patient's statements and conduct, the court held that the hospital visits were sufficient to support a finding of "imminent danger."[167]

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154 *Id.* at 1009.
155 *Id.*
156 *Id.* at 1010.
157 *Id.*
158 *Id.*
159 Coplan v. Miller, 179 N.E.3d 1006, 1010 (Ind. Ct. App. 2021).
160 *Id.*
161 *Id.*
162 *Id.*
163 *Id.* at 1011-12.
164 *Id.* at 1013.
165 Coplan v. Miller, 179 N.E.3d 1006, 1013 (Ind. App. 2021).
166 *Id.*
167 *Id.*

Indiana does not stand alone in requiring mental health professionals to consider the actions or circumstances of the patient's threat of violence.[168] Maryland, Massachusetts, and New Jersey require a therapist not only to warn of explicit threats but also to determine whether a patient's actions or the circumstances of a threat indicate imminent danger.[169] Indiana, Maryland, and Massachusetts specifically mandate that a therapist take into account the patient's past actions and propensity for violence.[170] Requiring a provider to look beyond actual threats of physical violence and take into consideration the full extent of the patient's conduct is likely to provide additional protection to potential victims.[171] However, expanding the duty to warn to the entirety of a patient's past actions could lead to confusion and uncertainty for many mental health providers when the patient's conduct does not demonstrate a strong propensity towards violence.

C. Permissive Duty-to-Warn Statutes

Permissive duty-to-warn states do not require a therapist to warn third parties of imminent threats.[172] Instead, these jurisdictions allow the breach of confidentiality to disclose such threats to authorities or potential victims.[173] Sixteen states fall within this category.[174] Permissive duty-to-warn statutes leave disclosure to the therapist's discretion, allowing them to break confidentiality to warn a third party of a patient's threat of violence without subjecting the therapist to civil liability for failure to warn.[175] For example, Oregon's statute provides that in "the professional's judgment" when a patient "indicates a clear and immediate danger to others or to society" during the course of treatment, the mental health provider "may [report] to the appropriate authority."[176] However, the statute explicitly states, "[a] decision not to disclose information . . . does not subject the provider to any civil liability."[177] The Oregon Supreme Court interpreted this statute to mean that there is "no duty to report, under Oregon law, but public health care providers have the discretion to do so."[178] Moreover, because permissive laws do not

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168 *See* Herbert & Young, *supra* note 84, at 278.
169 *Id*.
170 *Id*.
171 *See e.g.*, Coplan v. Miller, 179 N.E.3d 1006, 1013 (Ind. App. 2021).
172 Gamm, *supra* note 114, at 837.
173 *Id*.
174 Rothstein, *supra* note 7, at 106.
175 Herbert & Young, *supra* note 84, at 278-79.
176 OR. REV. STAT. ANN. § 179.505(12) (2022) (emphasis added).
177 *Id*.
178 State v. Miller, 709 P.2d 225, 236 n.8 (1985), *superseded by statute*, OR. REV. STAT. ANN. § 40.045 (2022), *as recognized in* Powers v. City of Salem, 771 P.2d 622, 628 n.13 (1989) (stating the Court's interpretation of Oregon's Permissive Duty to Warn statute is still good law, as it was superseded for its presumption that prejudice always resulted from a mistake in admitting evidence).

impose liability on the provider, they often have a lower threshold for the level of risk that triggers a therapist's ability to warn and may apply to a wider range of victims.[179] One significant difference between mandatory and permissive law is the type of potential victims that trigger the duty or ability to warn.[180] Mandatory duty-to-warn laws generally require an identified or identifiable victim, whereas permissive laws apply to a wider range of potential victims when there is potential harm to a person or the public.[181] This expansion is clearly noticed in the Oregon statute, which allows a provider to disclose when a patient is a "danger to others or to society."[182]

An essential variation among permissive states is the amount of discretion a statute affords to psychotherapists.[183] In states such as Texas and Oregon, therapists have true and complete discretion on whether to disclose patient communications.[184] For example, in Oregon, confidential patient information and patient communications may be reported to the appropriate authority if "in the professional judgment of the health care services provider" the patient is considered a "clear and immediate danger to others or to society."[185]

Texas's permissive *Tarasoff* statute has been interpreted by the Texas Supreme Court as an exception to confidentiality that provides for disclosure in certain circumstances.[186] In *Thapar v. Zezulka*, the court flatly rejected any *Tarasoff* duty in Texas.[187] The court concluded that Texas's statute *permits* mental health professionals to disclose patient threats to medical or law enforcement personnel but does not *require* disclosure of patient threats to prospective victims.[188] The problem posed by the Texas Supreme Court's permissive warning approach is that it provides little direction or protection to mental health professionals in addressing the potential consequences of a patient's threat of violence.[189]

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179 *Duty to Protect: Roles and Responsibilities for Psychologists*, APA PRAC. ORG. 1, 2 (2013), https://www.apaservices.org/practice/good-practice/duty-to-protect.pdf.

180 *Id.*

181 *Id.*

182 OR. REV. STAT. ANN. § 179.505(12) (2022).

183 Gamm, *supra* note 114, at 837.

184 Herbert & Young, *supra* note 84, at 279.

185 OR. REV. STAT. ANN. § 179.505(12) (2022).

186 Thapar v. Zezulka, 994 S.W.2d 635, 639 (Tex. 1999); *see* Current Tex. Health & Safety Code § 611.004(a)(2) (emphasis added), which adopts the same standard:

> (a) A professional *may* disclose confidential information only: . . .
> (2) to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient . . .

187 *Thapar*, 994 S.W.2d at 639.

188 *Id.* (emphasis added).

189 Sullivan, *supra* note 15, at 740.

The statute does not include warnings to an identified victim, thereby limiting disclosure of threats to "medical or law enforcement."[190] This provides significant protection for therapists because victims or their family members cannot bring actions against mental health professionals when threats are actualized and result in injury or death.[191] However, the therapist would be exposed to potential liability for any warning or other protective action if the therapist incorrectly assesses the seriousness of the patient's threat.[192] The Texas Supreme Court explained that the statute "does not shield mental-health professionals from civil liability for disclosing threats in good faith."[193] Rather, mental health professionals "make disclosures at their peril."[194]

This permissive approach, which fails to impose a statutory duty to warn and fails to provide immunity when warnings are given in good faith, subjects therapists to potential liability for acting in accordance with a moral duty to prevent violence or injury to a patient's intended victim.[195] This result can potentially place therapists in a position to decline action when confronted with uncertainty and instead favor inaction.[196] Although a provider may conclude that a patient is likely to engage in violence, the therapist may decline to act because of the risk of civil liability.[197] Statutes of this nature are likely to result in under-inclusion because a therapist may be unwilling to incur liability for disclosure of confidential patient information, even when the therapist believes the patient has the intent and ability to carry out such a threat.[198] However, Texas's position remains the minority view with respect to the duty to warn.[199]

Another problem posed by permissive duty-to-warn laws stems from a heightened risk of ethical violation.[200] For example, implicit bias may lead a therapist to be more suspicious of someone who acts, appears, or speaks in a particular manner.[201] When therapists have the ability to determine which individuals they should report, they may be more inclined to report members of one sex, socioeconomic group, culture, or religion over another.[202] This

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190 *Thapar*, 994 S.W.2d at 639.
191 Sullivan, *supra* note 15, at 741.
192 *Id.*
193 Thapar v. Zezulka, 994 S.W.2d 635, 640 (Tex. 1999).
194 *Id.*
195 Sullivan, *supra* note 15, at 741.
196 *Id.*
197 *Id.*
198 *See generally id.*
199 *Id.*
200 Joel M. Geiderman & Catherine A. Marco, *Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities,* 1 JACEP OPEN 38, 39 (2020), https://onlinelibrary.wiley.com/doi/epdf/10.1002/emp2.12011.
201 *Id.*
202 *Id.*

can lead to over-reporting because a mental health provider may be more inclined to make unnecessary warnings in states that both permit disclosures and provide immunity for such disclosures.[203]

Accordingly, the permissive approach can be both underinclusive and overinclusive.[204] A situation may be underinclusive in that therapists may fail to provide warnings, even when there is a serious threat of violence against a readily identifiable victim.[205] The potential consequence of these statutes suggests that therapists are not obligated to provide such warning or could incur liability to the patient for breach of confidentiality.[206] On the other hand, an overinclusive result may occur when a therapist provides unnecessary warnings, thereby damaging the therapist-patient relationship and hindering the effectiveness of treatment.[207] While this approach does not subject a therapist to liability for failure to warn a potential victim, therapists arguably face more difficulty in determining when to warn victims and, therefore, must rely on their sense of moral obligation to either protect the potential victim or preserve confidentiality with the patient.[208]

D. The Hybrid Approach

There are two states that take a hybrid approach to duty-to-warn laws: Florida and Illinois.[209] These states combine mandatory aspects with permissive aspects of the duty to warn; however, both laws achieve this goal in vastly different ways.[210] Florida's approach is simultaneously permissive and mandatory: a psychiatrist may report threats to a potential victim *and* has an affirmative duty to report threats to a law enforcement agency.[211] In contrast, Illinois' approach draws a distinction between the type of mental health professional.[212]

The Illinois Mental Health Code imposes a mandatory duty to warn by requiring psychologists and psychiatrists to report when a patient "has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victims."[213] In contrast, under the Illinois

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203 *See id.*

204 *See e.g.*, *id* at 38.

205 *See generally* Sullivan, *supra* note 15, at 741.

206 *See generally* Geiderman & Marco, *supra* note 200, at 39.

207 *See generally* Sullivan, *supra* note 15, at 741.

208 Rebecca Johnson et al., *The Tarasoff Rule: The Implications of Interstate Variation and Gaps in Professional Training*, 17 J. AM. ACAD. PSYCHIATRY L. 435, 437 (2014).

209 *See* FLA. STAT. ANN. §456.059 (2018); 405 ILL. COMP. STAT. ANN. 5/6-103 (2000); 740 ILL. COMP. STAT. ANN. 110/11 (2015).

210 *Id.*

211 FLA. STAT. ANN. § 456.059 (2018); Sullivan, *supra* note 15, at 762.

212 *See Duty to Warn and Reporting Threats of Harm: What You Need to Know,* JACKSON LLP (Nov. 11, 2021), https://jacksonllp.com/duty-to-warn-in-healthcare/.

213 405 ILL. COMP. STAT. ANN. 5/6-103 (2000).

Confidentiality Act, a therapist may disclose patient communications at the "therapist's sole discretion" when disclosure is "necessary to warn or protect a specific individual against whom a recipient has made a specific threat of violence."[214] This imposes solely a permissive requirement with no liability imposed on a therapist for failure to warn or to protect a potential victim if threats made by a patient are actualized.[215] Illinois courts have interpreted the Confidentiality Act as an "exception to the general rule against disclosures," which allows the therapist to disclose confidential information "when the therapist feels there is a threat of imminent risk to anyone, including the therapist," as long as the disclosure is made for the "purpose of preventing or avoiding the injury."[216]

On the other hand, Florida's approach varies depending on the person or agency the mental health professional intends to disclose the threat.[217] Traditionally, Florida took a permissive approach to *Tarasoff*[218] laws, allowing therapists to notify victims and law enforcement when "the patient has the apparent capability to commit such an act, and that it is more likely than not that in the near future, the patient will carry out that threat."[219] However, in the wake of the 2018 Parkland school shooting,[220] Florida implemented new legislation requiring mental health professionals to contact law enforcement while still maintaining a permissive element for contacting the potential victim directly.[221] The current Florida statute provides that when a psychiatrist learns of a "specific threat to cause serious bodily injury or death to an identified or a readily available person," they *may* disclose patient communications to the extent necessary to warn any potential victim and *must* disclose patient communications to the extent necessary to communicate the threat to a law enforcement agency.[222] This hybrid approach allows the psychiatrist discretion to disclose the patient's threat to

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214 740 ILL. COMP. STAT. ANN. 110/11 (2015).

215 *See Duty to Warn and Reporting Threats of Harm: What You Need to Know,* JACKSON LLP (Nov. 11, 2021), https://jacksonllp.com/duty-to-warn-in-healthcare/.

216 McNally v. Bredemann, 30 N.E.3d 557, 564 (2015).

217 *See* FLA. STAT. ANN. § 456.059 (2000).

218 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (1976).

219 FLA. STAT. ANN. § 456.059 (2019).

220 On February 14, 2018, Nicholas Cruz, a former student at Douglas High School in Parkland, Florida, killed seventeen students and teachers and wounded seventeen others. Cruz was treated for multiple mental health disorders by a therapist but discontinued therapy sessions a year before the shootings. *See* Terry Spencer, *School shooter's brain exams to be subject of court*, AP NEWS (Aug. 14, 2022), https://apnews.com/article/health-florida-fort-lauderdale-parkland-school-shooting-nikolas-cruz-3e95e3f24bff436544d8e3ab1e24efbb; Pollack v. Cruz, 296 So. 3d 453, 456 (Fla. Dist. Ct. App. 2020).

221 Ryan C. W. Hall & Irina Tardif, *Florida Law Enforcement Policies for and Experience With* Tarasoff*-Like Reporting*, 49 J. AM, ACAD. PSYCH. AND L. 1, 3 (2021).

222 FLA. STAT. ANN. § 456.059 (2019) (emphasis added).

the intended victim while simultaneously mandating the psychiatrist to report any threat to a law enforcement agency.[223]

The mandatory aspect of Florida's law provides an important level of protection for potential victims of a patient's violence by bringing law enforcement into the situation.[224] Requiring mental health professionals to report to law enforcement shifts the duty to warn or protect potential victims from the treating therapist to the agency charged with preventing violence.[225] This is likely more effective than a direct warning from the mental health professional in terms of preventing a potentially violent situation.[226] Since law enforcement agencies have more resources than mental health providers and an increased capacity to identify possible victims, it is seemingly appropriate to delegate notification to law enforcement.[227] A 2021 study suggested that 89.0% of Florida law enforcement agencies had policies in place for notifying potential victims and 91.4% had policies regarding notification of specific locations.[228] Moreover, the study concluded that 80.6% of the responding law enforcement departments had policies about monitoring a suspected victim or location, which indicated that notifying law enforcement had positive value for the safety of the potential victim or location beyond simply notifying the threatened person.[229]

Florida's statutory scheme also attempts to protect the therapist by providing that disclosure is only required when the therapist determines that the patient has both the intent and ability to carry out such a threat.[230] In other words, the statute requires a "clinical judgment that the patient has the apparent intent and ability to imminently or immediately carry out such threat."[231] The Florida approach defers to the mental health professional's assessment of the credibility of the patient's threat, the perceived seriousness of the patient's intent to commit the violent act, and the patient's ability to act on the threat.[232] Moreover, the statute protects the therapist issuing the required warning from civil liability.[233] The statute provides that a mental health provider's "disclosure of confidential communication when communicating a threat . . . may not be the basis of any legal action . . . or civil liability."[234] The statutory immunity provided by Florida's duty-to-warn law promotes the public policy of protecting third parties from violence,

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223 Sullivan, *supra* note 15, at 762.
224 *Id*. at 763.
225 *Id*.
226 *Id*.
227 Hall & Tardif, *supra* note 221, at 7.
228 *Id*.
229 *Id*.
230 Sullivan, *supra* note 15, at 763.
231 FLA. STAT. ANN. §456.059 (2018).
232 *Id*.; Sullivan, *supra* note 15, at 764.
233 *Id*.
234 FLA. STAT. ANN. §456.059 (2018).

while also protecting the therapist from civil liability for disclosing patient communications.[235]

The Florida statutory scheme attempts to strike a balance between the need for confidentiality and the protection of third persons.[236] However, it favors the latter interest by requiring mandatory reports to law enforcement while attempting to ensure that the breach of patient-therapist confidentially is not functionally ignored by only requiring disclosures when the therapist makes the determination that the patient has both the intent and ability to carry out such threat.[237] This approach is preferable because it provides heightened protection to the public by requiring communication with a collaborating agency, which is of significant importance when public violence is threatened.[238] Also, this approach provides some protection to the confidential relationship between provider and patient because the therapist is not obligated to disclose confidential information to potential victims.[239]

IV. THE IMPRACTICAL APPLICATION OF CHAOTIC DUTY-TO-WARN LAWS AND THE NEED FOR CLARITY

In the years following the *Tarasoff* ruling, the practical problems inherent in the implementation of the current duty-to-warn laws became a major concern within the mental health community.[240] Ambiguity concerning the application of the duty to warn can arise because of the lack of clarity in the laws, the conflicting duties of confidentiality and protection of the public, and the inexact science of predicting violence.[241]

The myriad of ambiguous laws, regulations, and legal rulings have created confusion for mental health providers regarding what is confidential, when confidentially should be breached, and what specific actions mental health providers must take in these situations.[242] Challenges involving the implementation of the duty to warn may also be linked to the lack of clear, effective guidelines defining the terms of their duty to third persons.[243]

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235 Sullivan, *supra* note 15, at 764.

236 *Id.* at 765.

237 FLA. STAT. ANN. §456.059 (2018); *id.*

238 *See generally* Hall & Tardif, *supra* note 221, at 1.

239 *See generally* FLA. STAT. ANN. §456.059 (2018); Sullivan, *supra* note 15, at 765.

240 *See generally* Karen Tapp & Darrell Payne, *Guidelines for Practitioners: A Social Work Prospective on Discharging the Duty to Protect*, 8 J. SOC. WORK VALUES & ETHICS 1, 5-6 (2011).

241 G. Andrew H Benjamin and Connie J. Beck, *Major Legal Cases That Have Influenced Mental Health Ethics*, *in* THE CAMBRIDGE HANDBOOK OF APPLIED PSYCHOLOGICAL ETHICS 429, 438 (Mark M. Leach & Elizabeth Reynolds Welfel ed., 2018).

242 Jeffrey E. Barnett & Caroline Coffman, *Confidentiality and its Exceptions: The Case of Duty to Warn*, SOC'Y FOR ADVANCEMENT PSYCHOTHERAPY, https://societyforpsychotherapy.org/confidentiality-and-its-exceptions-the-case-of-duty-to-warn/ (last visited Sep. 4, 2023).

243 Ginger Mayer McClarren, Comment, *The Psychiatric Duty to Warn: Walking A Tightrope of Uncertainty*, 56 U. CIN. L. REV. 269, 286 (1987).

Mental health providers are frequently held liable for failing to adequately warn a potential victim, even though the law has not made clear what constitutes an "adequate" warning.[244]

A 2009 study of 300 psychologists in four states with varying legal obligations concerning the duty to warn found that 76.4% of psychologists had misunderstandings about their respective state's laws.[245] Some of the psychologists believed that a legal duty to warn arose when it did not, while others believed that a warning was their only legal recourse when other protective options were available.[246] Moreover, 89% of the participating psychologists were confident that they understood the duty to warn/protect in their own jurisdiction.[247] The uncertainty faced by mental health providers regarding their legal obligations is often attributed to the highly complex and contradictory laws and regulations, as well as the unclear definition of "dangerousness."[248] Additionally, the lack of clear guidance concerning a therapist's professional obligations makes it challenging for mental health professionals to know when the duty to warn arises and how to implement the duty to warn into their clinical practice.[249]

Implementing the duty to warn and protect doctrine can often present complex and challenging ethical dilemmas that require intricate clinical judgments for mental health professionals.[250] Therapists must balance immediate client welfare with the best interest of society and, at the same time, protect themselves from legal ramifications that may result from a failure to warn or breach of confidentiality.[251] For example, a provider may feel strongly that a particular circumstance justifies a breach of therapist-patient confidentiality but is ultimately mistaken.[252] That provider could then be held liable to the patient for the breach of confidentiality, regardless of whether the provider was acting in good faith.[253] Conversely, a provider who favors confidentiality over the issuance of a warning could be subject to civil liability for the failure to warn a threatened third party.[254]

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244 *Id.*

245 Yvona L. Pabian et al., *Psychologists' knowledge of their states' laws pertaining to Tarasoff-type situations*, 40 PRO. PSYCH. RSCH. PRAC. 8, 8 (2009).

246 *Id.*

247 *Id.*

248 Jeffrey E. Barnett & Caroline Coffman, *Confidentiality and its Exceptions: The Case of Duty to Warn*, https://societyforpsychotherapy.org/confidentiality-and-its-exceptions-the-case-of-duty-to-warn/ (last visited Sep. 4, 2023).

249 *Id.*

250 Luann Costa & Michael Atekruse, *Duty-to-warn guidelines for mental health counselors*, 72 J. COUNSELING DEV. 346, 346 (1994).

251 *Id.*

252 Ahmad Adi & Mohammad Mathbout, *The Duty to Protect: Four Decades After Tarasoff*, AM. J. PSYCHIATRY (2018), https://psychiatryonline.org/doi/10.1176/appi.ajp-rj.2018.130402.

253 *Id.*

254 *Id.*

Challenges involving the implementation of the duty to warn may be attributed to how United States jurisdictions define "dangerousness" and the requirement of imminence.[255] While "imminent" violence towards self or others is a term firmly embedded in the language of psychiatry and the law, there is no evidence-based research that supports the proposition that clinicians can accurately predict when, or even if, an individual will commit an act of violence.[256] Nevertheless, eighteen states and the District of Columbia require that to establish a duty to warn or protect, a threat made against a potential victim be "imminent" or "immediate."[257] In the states that explicitly require that the violence be "imminent" to give rise to a duty to warn, clinical commentators often provide different definitions of how the law ought to be interpreted, ranging from a few days to a few weeks to several months.[258] For example, one commentator defined "imminent" violence as occurring "within three days" of the prediction of violent behavior towards another.[259] Another researcher found that the measure of "imminent" violence was whether a patient would or would not engage in violent conduct within one week following a psychological risk assessment.[260] Others define imminence more vaguely. For example, the California Department of Health Care Services defined "imminent" as "about to happen or ready to take place."[261]

Moreover, imminence sets the bar too high for disclosure and leaves mental health professionals attempting to apply an impractical standard.[262] Although the imminence requirement is generally intended to limit the duties of mental health professionals,[263] it leaves the therapist with the impossible task of divining the meaning of "imminent" danger.[264] For example, a mental health professional may believe that a patient with a history of violence who has made credible threats did not indicate that they were planning to take imminent action to carry out those threats, which could leave the therapist uncertain as to whether they are under a legal duty to warn the potential

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255 *Id.*

256 Simon, *supra* note 53, at 637.

257 Rothstein, *supra* note 7, at 107.

258 Johnson et al., *supra* note 208, at 471.

259 *See* JOHN MONAHAN, PREDICTING VIOLENT BEHAVIOR: AN ASSESSMENT OF CLINICAL TECHNIQUES 134 (1981).

260 Paul D. Werner et al., *Aspects of Consensus in Clinical Predictions of Imminent Violence*, 46 J. CLINICAL PSYCH. 534, 535 (1990).

261 *Rights for Individuals in Mental Health Facilities Admitted Under the Lanterman-Petris-Short Act*, CAL. DEPT. HEALTH CARE SERV. 1, 29, https://www.dhcs.ca.gov/services/Documents/DHCS_Handbook_English.pdf.

262 Rothstein, *supra* note 7, at 107.

263 *See id.*; Simon, *supra* note 53, at 637.

264 Simon, *supra* note 53, at 638.

victim and, thereby expose the therapist to liability if the therapist is ultimately mistaken.[265]

The American Psychiatric Association (APA) abandoned the imminence standard in its medical code of ethics.[266] Specifically, The APA's The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry ("The Principles of Medical Ethics") banished the word "imminent" in its 2006 edition.[267] Currently, The Principles of Medical Ethics states, "[w]hen, in the clinical judgment of the treating psychiatrist, the risk of danger is deemed to be *significant*, the psychiatrist may reveal confidential information disclosed by the patient."[268] Replacing "imminent" with "significant" shifts the focus from the time in which the patient may commit the violent act to whether the patient has demonstrated capacity to carry out such a threat.[269] This allows the therapist to focus on the patient's history of violence, the situational triggers that have exacerbated violence in the past, and what can be done to intervene.[270]

The confusion surrounding the imminence standard shows that legislatures should focus less on the immediacy of the threat and more on the patient's demonstrated capacity to carry out the threat.[271] Focusing on the patient's capacity to commit the future act may increase the effectiveness of the duty to warn and provide further protection to potential victims because it is consistent with the role of a mental health professional.[272] Psychologists and other mental health practitioners often conduct risk assessments to predict the likelihood that an individual might act violently in the future.[273] The information relevant to conducting risk assessments includes childhood experiences, previous violent history, personality structure, degree of mental health, relationship status, and use of alcohol.[274] Moreover, the context, opportunity, frequency, and severity of past dangerous behavior and the identification of circumstances that trigger dangerous behavior are essential

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265 Rothstein, *supra* note 7, at 107.

266 *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, AM. PSYCHIATRIC ASS'N, 1, 7 (2013), https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf.

267 Simon, *supra* note 53, at 638.

268 *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, *supra* note 266, at 7.

269 *See* Johnson et al., *supra* note 208, at 471.

270 *See id.*

271 *Id.*

272 *See generally* Jan Chaiken, et al., *Predicting Violent Behavior and Classifying Violent Offenders*, *in* UNDERSTANDING AND PREVENTING VIOLENCE, VOLUME 4: CONSEQUENCES AND CONTROL 217, 245 (Nat'l Acad. Press, 1994).

273 Stephen Rochefort, *Risk Assessment: Predicting Future Violence*, VIE PSYCH., https://www.viepsychology.com/2016/11/04/risk-assessment-predicting-future-violence/ (last visited Aug 27, 2023).

274 *Id.*

to a competent and reliable risk assessment of future dangerousness.[275] According to a recent study, a person's past conduct, antisocial or self-destructive behavior, may be indicative of the frequency and seriousness of future violent behavior.[276] Specifically, the frequency and seriousness of the other forms of socially undesirable and self-destructive behaviors are indicative of the frequency and seriousness of future violent behavior.[277] Aligning legal requirements for the duty to warn with the current research and methodology used by mental health professionals when making predictions of future violence could likely increase the effectiveness of the mental health community and provide additional protection to the public.[278]

Interestingly, *Tarasoff* never imposed an "imminence" or "immediacy" requirement.[279] This requirement likely would not have been satisfied because Poddar did not kill Tatiana until ten weeks after disclosing to Dr. Moore that he intended to harm Tatiana.[280] Perhaps this is what led the California Supreme Court to focus on the foreseeability of the harm over the immediacy of Poddar's dangerous actions.[281] However, foreseeability has been described as "a cliché" and a "legal fiction as applied to the clinical assessment of violence."[282] Moreover, requiring therapists to determine the meaning of imminence and foreseeability could distract from patient care and interfere with the critical decision-making of mental health providers.[283]

Accordingly, to interrupt acts of violence and increase the mental health communities' effectiveness at managing potential threats, the duty to warn should focus on the risk of danger that is deemed to be significant by the mental health professional, the patient's intention to carry out such harm, and the patient's demonstrated capacity to carry out such harm. Moreover, the duty to warn should be focused on the obligation to assess violence according to a standard of reasonable care, which therapists may achieve in their clinical practice, and not a duty to predict violence accurately.[284]

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275 Robert T. M. Phillips, *Predicting the Risk of Future Dangerousness*, 14 VIRTUAL MENTOR 472, 474 (2012).

276 Chaiken et al., *supra* note 272, at 245.

277 *Id.*

278 *See generally id.*

279 *See* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976).

280 *Id.* at 341.

281 *See id.* at 346; Rothstein, *supra* note 7, at 107.

282 Simon, *supra* note 53, at 636.

283 *Id.* at. 643.

284 James C. Beck, *The Psychotherapist's Duty to Protect Third Parties from Harm,* 11 MENTAL AND PHYSICAL DISABILITY L. REP. 141, 147 (1987); Emerich v. Phila. for Human Development, Inc., 720 A.2d 1032, 1040 (Pa. 1998).

V. A PROPOSAL FOR A MODEL STATUTE THAT IS CLEARLY DEFINED AND PRAGMATICALLY EFFECTIVE IN THE TREATMENT SETTING

The jurisdictional variance of this legal doctrine is abundant, and the variety of the duty-to-warn laws across the nation produces an element of unpredictability and confusion for mental health providers and the community therein.[285] This unwanted result contributes to a reluctance to act because of "the conundrum a mental health care professional faces regarding the competing concerns of productive therapy, confidentiality, and other aspects of the patient's well-being . . . [and] public safety."[286] This Note does not seek to strike a complete balance between provider-patient confidentiality and the protection of public safety, nor does it provide a conclusive answer on how to prevent acts of mass violence in the future. Rather, this Note proposes a model statute that seeks to clarify therapists' duties regarding the treatment of potentially violent patients. While the need for effective and confidential mental health treatment must be balanced with the interest of protecting society from violent acts, legislatures must be cognizant of the difficulty of accurately predicting future dangerousness and afford protection to therapists implementing the duty to warn.[287]

In addition, state legislatures should define the scope of when a therapist's duty to warn arises, to whom the duty is owed, and what preventive actions must be taken to discharge such duty. They should also afford immunity to therapists for disclosures of confidential information and failure to predict a patient's dangerousness accurately. Moreover, state legislatures should provide effective statutes, which eliminate "imminent" from providers' duty to warn. The therapeutic relationship and protection of the public will arguably benefit if legislatures pass clearly defined laws and ensure that therapists are able to efficiently integrate such duties within their practice.

A model statute should provide:

> A mental health provider has a duty to warn the appropriate law enforcement agency and the potential victim or victims when a patient has communicated an actual threat of physical violence deemed to be significant by the provider, or evidences conduct indicating significant risk that the patient will use physical violence or other means to cause serious personal injury or death to a reasonably identifiable victim or victims, including those that are identifiable by their association with a specific location or entity. A mental health provider shall discharge the legal duty to

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285 Gamm, *supra* note 114, at 839.

286 Rothstein, *supra* note 7, at 108.

287 *See generally id.*

> warn or protect by notifying the appropriate law enforcement agency and the potential victim or victims, arranging for the patient's voluntary hospitalization, or petitioning for involuntary hospitalization. A law enforcement agency that receives notification from a mental health provider of a threat must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order.
>
> No civil liability or cause of action may arise against a mental health professional for failure to predict, warn, or take precautions to protect from a patient's violent behavior if a provider has, in good faith, made reasonable efforts to assess the patient's violent behavior, and their reasonable efforts fail to reveal an actual threat or evidence of violent conduct against a reasonably identifiable victim or victims, including those that are identifiable by their association with a specific location or entity. No civil liability or cause of action shall arise against a mental health provider based on an invasion of privacy or breach of confidentiality for any confidence disclosed to law enforcement or potential victims in an effort to discharge the duty arising under this section.

A model statute, such as the one above, provides public redress when a patient engages in foreseeable violence. However, it holds mental health professionals to a practical standard of conduct and encourages providers to improve their efforts in assessing potentially violent patients. Moreover, it protects mental health providers, which would substantially decrease the fear of liability felt by many practitioners in the mental health community and accounts for the difficulties of predicting future violence.

By including the language "a mental health professional has a duty to warn" there is little doubt as to the existence of an affirmative duty to act in the specified circumstances. This helps clarify the ambiguity mental health providers face when determining whether they have a duty to warn a potential victim or law enforcement. Also, the model statute clearly specifies the circumstances that give rise to the duty to warn, which will likely minimize unnecessary breaches of confidentiality.[288] Although imposing a duty to warn on mental health professionals when a patient's actions or conduct indicate the potential for violence will likely create additional liability for mental health professionals, it encourages mental health professionals to conduct reasonable risk assessments for future violence.[289] Moreover, limiting the duty to warn to specific threats of imminent violence is underinclusive, thereby exposing foreseeable victims to preventable violence.[290] Thus, the

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288 *See* Wood, *supra* note 18, at 598-99.

289 *See* James C. Beck, *The Psychotherapist's Duty to Protect Third Parties from Harm,* 11 MENTAL AND PHYSICAL DISABILITY L. REP. 141, 147 (1987).

290 *See* Rothstein, *supra* note 7, at 107.

expansive language of the model statute is needed to protect the public from "dangerous" patients.[291]

Requiring mental health professionals to warn appropriate law enforcement agencies could also afford greater protection to the public because notifying law enforcement and promptly warning the potential victims provides a safer and simpler course of action.[292] Reporting threats to police officers will likely have a large impact when threats are made about public places or locations because of police officers' ability to monitor locations or suspected victims.[293] Moreover, studies have shown that notifying law enforcement has increased social benefits for the safety of the threatened person or location beyond simply notifying the potential victims.[294] Thus, communication with a collaborating agency is of significant importance when public violence is threatened.[295]

While many psychotherapists have proposed that liability should not be triggered until the patient has made a threat directly to the therapist concerning a named victim, issues arise with this standard because it permits a clinician to avoid liability by failing to conduct an adequate assessment of potential violence.[296] Rather, clinicians should be held to a professional standard for determining whether they have conducted an adequate evaluation of potential violence.[297] As stated in *Tarasoff, "*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."[298] This holds mental health professionals to a practical standard of conduct and encourages providers to improve their efforts in assessing potentially violent patients.[299] It also ensures mental health professionals are held accountable when there are credible threats of violence or the patient presents clear conduct that they intend to engage in violent behavior towards an identifiable person or specific location.[300]

Scholars have rejected the expansion of the duty to warn to include threats made against a specific location.[301] Specifically, it has been argued that expanding a therapist's duty to warn to encompass threats against persons who are "identifiable by their association with a specific location or

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291 *See id.*
292 Herbert & Young, *supra* note 84, at 278.
293 Hall & Tardif, *supra* note 221, at 7.
294 *Id.*
295 *Id.*
296 *See* Beck, *supra* note 289, at 147.
297 *See id.*
298 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 339 (Cal. 1976).
299 *See e.g.*, Beck, *supra* note 289, at 147.
300 *See e.g., id.*
301 *See* Gamm, *supra* note 114, at 845.

entity" exposes therapists to additional liability and exacerbates practical issues within the mental health profession.[302] However, the extension of the potential victims to include threats made to a specific location may provide additional protection to the community and allow mental health professionals to intervene and prevent violence before it occurs.[303] Moreover, since mass shootings have increasingly targeted different venues in recent years, such as churches, schools, synagogues, grocery stores, and movie theaters, including language that encompasses specific locations within duty-to-warn statutes could help prevent future acts of mass violence.[304]

In light of recent mass shootings against supposedly random victims, requiring a warning based on a specific "location or entity" seeks to prevent acts of violence against both readily identifiable and random victims,[305] thus affording greater protection to the public. Moreover, expanding the duty to warn to encompass specific locations does not expose therapists to additional liability when legislatures combine a mandatory duty to warn with immunity for reporting.[306] In that instance, psychotherapists are protected from civil actions that may arise from the disclosure of patient information or failure to adequately predict future violence.[307]

Scholars also contend that mandatory reporting laws often raise important ethical questions because they prioritize public and patient welfare and set aside the provider's duty to protect confidentiality.[308] Reporting that overrides patient confidentiality is often believed to result in patients losing trust in providers or avoiding treatment altogether, which would be detrimental to the patient-therapist relationship.[309] However, as stated in *Tarasoff*, when a therapist's disclosure is necessary to avoid physical harm or death to others, it is "not a breach of trust or a violation of professional ethics . . . ."[310] This is because "public policy favoring protection of the confidential character of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others."[311]

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302 Gamm, *supra* note 114, at 845 (quoting COLO. REV. STAT. § 13-21-117(2023)).

303 The Associated Press, *House proposal would expand duty to report threats*, THE DENVER PRESS (Mar. 5, 2014), https://www.denverpost.com/2014/03/05/house-proposal-would-expand-duty-to-report-threats/ (explaining that when Colorado changed its law to include "specific location or entity," Colorado Democratic Rep. Jovan Melton said, "[s]o therefore if a threat is made toward one of our schools, or a theater, or some other public place, the therapist will then be able to have the tools to work with law enforcement and really protect our public interests and public safety.").

304 Faith Karimi, *Mass shooters are increasing attacking 'soft targets' such as supermarkets. Experts say securing them will be difficult*, CNN (May 20, 2022, 7:10 AM), https://www.cnn.com/2022/05/20/us/mass-shooters-soft-targets-challenges-cec/index.html.

305 Sullivan, *supra* note 15, at 755.

306 *See e.g.*, COLO. REV. STAT. ANN. § 13-21-11 (2022).

307 *See e.g.*, *id.*

308 Geiderman & Marco, *supra* note 200, at 39.

309 *Id.*

310 Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 347 (Cal. 1976).

311 *Id.*

Mandatory duty-to-warn laws are also believed to have a large economic and professional impact on mental health providers.[312] However, courts have rejected this argument because "the execution of the duty to warn only requires a simple telephone call to the victim or other appropriate authorities."[313] Thus, "[t]he burden imposed on the individual in fulfilling this duty is greatly outweighed by the potential or actual harm suffered as a result of failure to fulfill this duty."[314]

This Note is only concerned with one small part of the *Tarasoff* doctrine.[315] The duty to warn is far more complex than presented here, and various issues still remain, including possible deterrence of patients seeking psychiatric help and lack of trust in a provider. While this proposal does not fix all issues concerning duty-to-warn laws, it attempts to provide clarity to therapists, and provide heightened protection to the public. Admittedly, this proposed statute does not strike a perfect balance between provider-patient confidentiality and public protection. However, it does afford greater protection to the public, less exposure to liability on the part of the therapist, and clarifies the duty to warn in order to decrease the risk of unnecessary warnings.

VI. CONCLUSION

In the United States, state variations of legal doctrines are anticipated and often preferred.[316] However, the significant variation of duty-to-warn laws, with few states agreeing on a common approach, is nearly unprecedented for any prevalent legal doctrine.[317] Confusion is an unavoidable consequence of the chaotic *Tarasoff* laws currently in effect, which are inefficient and possibly even detrimental to the mental health community and the therapeutic relationship.[318] To mitigate the ambiguity surrounding *Tarasoff* laws, state legislatures should adopt an unambiguous approach to the duty to warn by clearly defining the scope of when a therapist's duty to warn arises, whom the duty is owed, what preventive actions must be taken to discharge such duty, and afford immunity to therapists for disclosures of confidential information and failure to accurately predict a patient's dangerousness.

Moreover, given the potential harm to the public from mass shootings, the introduction of a clearly defined duty to warn could interrupt future

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312 Bradley v. Ray, 904 S.W.2d 302, 310 (Mo. Ct. App. 1995).
313 *Id.*
314 *Id.*
315 *See generally Tarasoff*, 551 P.2d at 334.
316 *See* Herbert & Young, *supra* note 84, at 274.
317 *Id.* at 278.
318 *Id.*

instances of violence and increase the mental health communities' effectiveness at managing potential threats. Although perpetrators of mass violence are rarely driven by psychotic symptoms, mental health providers are commonly involved when persons make overt threats against others or evidence conduct that raise such concerns.[319] For the small number of persons who have mental illness that constitute a threat to themselves or others, it is necessary for there to be unambiguous and well-understood legal standards regarding the duty to warn.[320] Thus, mental health professionals must be able to determine when such duty arises to efficiently protect the public from persons that threaten mass violence.[321] When such potential violence is at stake, it is of utmost importance that the mental health community communicate with local law enforcement agencies to prevent acts of mass violence before they occur.[322]

Admittedly, duty-to-warn laws are unlikely to avert all acts of mass violence, especially when there is no indication of violent tendencies or the perpetrator does not seek psychiatric treatment prior to committing a mass attack.[323] However, given the critical role mental health providers play in preventing acts of mass violence,[324] implementing effective and clearly defined statutes could mitigate the risk of violent persons committing mass murder because the mental health community would be better equipped to prevent acts of violence by acting on their duty to warn.

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319 Amy Barnhorst & John S. Rozel, *Evaluating threats of mass shooting in the psychiatric setting*, 33 INT'L REV. PSYCHIATRY 607, 613 (2021).

320 *See id.*

321 *See id.*

322 *See id.*

323 *See* Shaila Dewan, *What Are the Real Warning Signs of a Mass Shooting?*, N.Y. TIMES (Aug. 23, 2022), https://www.nytimes.com/2022/08/22/us/mass-shootings-mental-illness.html.

324 *See* Peterson & Densley, *supra* note 8, at 20-21.