Court Responses to *Tarasoff* Statutes

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Twenty-three states have enacted *Tarasoff* statutes applicable to psychiatrists. Since the first such statute was enacted in California in 1985, a significant number of courts in states with this and similar statutes have reviewed *Tarasoff*-type claims. This article reviews courts' analyses in 76 such cases. There were five basic categories identified, including cases that (1) did not reference the statute; (2) referenced the statute, but did not analyze it; (3) referenced the statute, analyzed it, and found it created a duty; (4) referenced the statute, analyzed it, but found it did not create a duty; and (5) referenced the statute in the context of testimonial privilege. Review of these cases revealed that even in states that have *Tarasoff* statutes, clinicians must continue to rely on their clinical and ethical judgment, rather than statutory guidance, when considering potential protective disclosures or future drafts of protective disclosure statutes.

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The Supreme Court of California's *Tarasoff* decision in 1976[1] brought to California psychotherapists a duty to protect others from the violent acts of their patients—a duty that included the communication of verbal warnings. Especially since the American Psychiatric Association had argued in its brief to the California court[2] that psychiatrists had no standard for predicting dangerousness and that the risks of such a duty could outweigh any protective benefits, psychiatrists and other mental health professionals naturally awaited the court decisions to follow, in California and other states, with anxious concern. Court decisions that followed were, all in all, even more disconcerting because of their variance, one from the other, and their seeming unpredictability.

If not already clear from the *Tarasoff* principle itself, the Superior Court of Law, Legal Division, in New Jersey demonstrated in *McIntosh v. Milano*[3] that courts would not confine the protective duty to factual situations in which a verbal threat was expressed. The Supreme Court of California then appeared to place some restrictions on the application of the duty to protect in *Thompson v. County of Alameda* in 1980.[4] Although this description of when the duty arises seemed more specific and concrete and was therefore regarded as some reassurance among mental health professionals, the so-called *Thompson-Tarasoff* rule still left to interpretation the meaning of "predictable threat." In *Hedlund v. Superior Court of Orange County*[5] the Supreme Court of California recognized that protective duties could extend to an unnamed, unthreatened victim, if it were foreseeable that such a victim would be in the presence of a targeted victim and therefore shared the risk; but even the targeted victim need not have been named or specifically threatened by the patient for the protective duty to apply, according to the Ninth Circuit Court of Appeals in another California case.[6]

Outside California, duty to warn/protect cases were, as anticipated, heard by courts in other states. Rules established by other courts, as has been summarized elsewhere,[7] varied greatly, some more expansive than the *Tarasoff* principle, others, more restrictive. Such rules included, for example, foreseeable violence, foreseeable victim, identifiable victim, specificity, and zone of danger. Already, by 1982, at least one court[8] had found no legal duty to protect without a legally controlling relationship over the patient. If psychiatrists in California faced the possibility of indeterminate expansion of third-party liability, those in other states faced even greater uncertainty about what form legal duty to protect others would take in their jurisdictions.

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In the quest for greater clarity, predictability of judicial application, and clinical practicality, psychiatrists and other professionals in California successfully appealed to the state legislature for enactment of a statute that would clarify when a warning is permissible (thus addressing the confidentiality dilemma) and provide liability protection for therapists who acted in compliance with this statute. Thus, the first of the so-called *Tarasoff* or protective disclosure statutes was enacted and signed into law in 1985. In 1988, Appelbaum *et al.*[9] comprehensively reviewed this and 11 other protective disclosure statutes that followed. Today, 23 such statutes pertaining to psychiatrists have been enacted. Although not for psychiatrists, additional statutes in still other states provide statutory guidance and some liability protection for other professionals.

Over a quarter of a century after the *Tarasoff* decision and 18 years after the first *Tarasoff* protective disclosure statute, this is a fitting time to review court decisions in states with such statutes. To what extent do courts base their decisions on the protective disclosure statutes of their state? Have these statutes made a difference after all? Answers to these questions are important for both clinicians who endeavor to practice legally and policy makers who shape the legal framework in which psychiatrists apply their trade.

In pursuit of answers to these questions, first, a search for states that have enacted protective disclosure statutes was completed. A search for cases in those states, decided after the statutes were enacted, that involved "duty to warn" or *Tarasoff*-type situations, followed. After these searches were completed, each court decision was reviewed regarding its approach to the statute. This review included analysis of how and whether the court considered the statute at all in arriving at a holding.

In the search for statutes, only those resulting from the aftermath of the *Tarasoff* decision, and not those that, loosely construed, could be considered to establish a specific duty to third parties (e.g., statutes allowing disclosure for purposes of civilly committing a person who generally poses a danger to self or others) were included. Furthermore, only those statutes that applied to psychiatrists among those therein referenced were included. As previously noted, many such statutes apply solely to other professionals, including psychologists, social workers, family therapists, and other "counselors."[10]

For purposes of this article, a *Tarasoff*, or protective disclosure, statute must apply to psychiatrists, contain some type of specificity rule (i.e., require an actual threat to an identifiable victim), and include some type of immunity for disclosure. These inclusion criteria sufficiently restrict the focus to statutes enacted as a consequence of the psychiatrist's duty to nonpatient third parties as established by *Tarasoff* and its progeny.

Regarding the subsequent search for cases, inclusion criteria were not as restrictive. Included was any case in a state with a protective disclosure statute that was decided after the statute was enacted, involved an injured third party's suing a mental health professional, and/or cited the statute in some type of protective disclosure context. Cases not involving a mental health professional, but addressing a duty to warn a third party based on the statute, were also included, since they provide some insight into the court's view toward the statute. A few nonincluded cases cited the statute, but for purposes unrelated to *Tarasoff* questions (e.g., in exploration of the appropriate definition of "serious bodily injury").[11] In some states, the protective disclosure provisions are part of a broader statute addressing multiple exceptions to nondisclosure, such as compliance with child abuse or sex offender reporting laws. Only when a case cited the particular protective disclosure provision, as opposed to any of the other allowed exceptions enumerated in the same statute, was the case included. Finally, the focus was on appellate or state supreme court decisions, as most lower court decisions are not published.

Although the search was exhaustive, not every case involving duties to third parties since these statutes were enacted was included. As mentioned, many lower court decisions are not published, yet may have an impact on clinical practices in the local area. Furthermore, litigation is not a static process. Unlike legislatures that are only in session at certain times, courts, for the most part, are always in session and new cases are decided continually. However, most relevant higher court decisions are included and provide a sufficient database for this review.

Review of Statutes

This article focuses on the manner in which a court interprets a statute in terms of whether the statute establishes a duty to a third party and, if so, whether the statute restricts such a duty. Therefore,

language in the statute describing the circumstance under which a duty may arise, rather than discharge of the duty, or immunity provisions of the statute, is relevant.

Twenty-three states' statutes met the inclusion criteria. The statutes were divided into four categories based on how the duty was addressed.

Statutes That Seem Explicitly to Establish a Duty

These statutes contain terminology that appears to create a definite duty, such as "a mental health professional *has a duty*. . ." (all italic type has been added for emphasis). States with this type of statute are Idaho, Michigan, Montana, New Hampshire, and Virginia (see Table 1 for citations not referenced in text).

Statutes that Prohibit Liability Except Under Specified Circumstances

The majority of statutes fall within this category that appears to create a duty, but in a less direct manner. These statutes are phrased in a conditional manner: "There can be no cause of action and no liability. . .*unless*. . . ." States with this type of statute are Arizona, Colorado, Delaware, Indiana,[12] Kentucky, Louisiana, Maryland, Massachusetts, Nebraska,[13] New Jersey, Tennessee, and Utah.

Statutes that Seem to Be Permissive

In this category, the statutory language appears to allow, but not to require, disclosure. For example, "The psychiatrist *may* disclose. . ." Only two states, Florida and Mississippi,[14] follow this pattern.

Statutes That Take Other Approaches

Four states, California, Illinois, Ohio, and Washington, have statutes with unique approaches that do not fall into any of the previous categories and are not found in any other state.

First, the California statute, the first *Tarasoff* statute, if strictly read, initially seems, as in the second category mentioned, to establish a duty indirectly; but in the next paragraph, its language places the existence of such a duty in doubt:

> (a) *There shall be no monetary liability* on the part of, *and no cause of action shall arise* against, any person who is a psychotherapist. . .in failing to warn of and protect from a patient's violent behavior *except* where the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.
>
> (b) *If there is a duty* to warn and protect under the limited circumstances specified above, the duty shall be discharged by. . . .

This seems to be an attempt to acknowledge the growing case law in the state by clearly delineating when protective action might be taken and providing immunity when action is taken, but without conceding that a duty to take such action exists. Therefore, one might consider this to be another permissive statute.

The Ohio statute,[15] in the final analysis, also appears to be permissive: "A mental health professional. . .*may be held liable*. . .*only if*. . .," but uses language that places that assumption in some doubt.

Illinois has two statutes that address a protective disclosure in a *Tarasoff*-type situation. The first is in a section entitled "Good faith; exemption from liability" and includes exemptions from liability for disclosure in a number of situations. One exemption is for "failure to warn of and protect from" a patient's violence "except where the recipient has communicated to the person a serious threat of physical violence against a reasonably identifiable victim or victims"—thereby prohibiting liability except under specified circumstances.

However, another section, addressing "Disclosure of records and communications," contains a provision stating that there may be disclosure "when, and to the extent, in the therapist's sole discretion, disclosure is necessary to warn or protect a specific individual against whom a recipient has made a specific threat of violence where there exists a therapist-recipient relationship or a special recipient-individual relationship." While the previous section appears to create a conditional duty, this provision appears to be permissive.

Finally, Washington, similar to Illinois, has two statutes that reference a possible *Tarasoff*-type duty, one in a section entitled "exemptions from liability" providing that:

> (1) No. . .*mental health professional*. . .*shall be civilly or criminally liable* for performing duties. . .with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications or detain a person for evaluation and treatment. . .(2) *This section does not relieve a person from*. . .the duty to warn or to take reasonable precautions. . .The duty. . .is discharged if. . .

The other is in a section entitled "confidential information and records-disclosure" and provides ". . .Information and records *may* be disclosed

Table 1 Court Responses to *Tarasoff* Statutes

State (Statute)	Case (Year)	Court	Approach*
Approaches:			
1. Cases not referencing the statute			
2. Cases referencing the statute, but not using it in their analysis			
3. Cases referencing the statute, using it in their analysis, and finding that it creates a duty,			
a. but finding it unconstitutional			
b. and finding that the facts fell within the statutorialy defined circumstances			
c. and finding that the facts did not fall within the statutorily defined circumstances			
d. and finding that the facts did not fall within statutorialy defined circumstances, but that there may be/still is a common law duty			
e. and finding that the facts fell within statutaroily defined circumstances and that the statute abrogates any common law duty			
4. Cases referencing the statute, using it in the analysis, but finding that it does not create a duty			
5. Cases referencing the statute in the context of testimonial privilege			
Arizona			
A.R.S. § 36-517.02 (1989)	Little v. All Phoenix South Community Mental Health Center, 919 P.2d 1368 (1995)	Court of Appeals	3a
	Tamsen v. Weber, 802 P.2d 1063 (1990)	Court of Appeals	1
California			
Cal. Civ. Code § 43.92 (1985)	Silvaz ex rel. Ayala v. South Bay Community Services, 2003 WL 23419 (2003) (nonpublished) (2003)	Court of Appeals, Fourth District	2
	Suzuki v. Eli Lilly & Co., 2002 WL 258263 (2002) (nonpublished) (2002)	Court of Appeals, Second District	3c
	People v. Felix, 112 Cal. Rptr.2d 311 (2001)	Court of Appeals, Second District	2
	Tilley v. Schulte, 82 Cal. Rptr.2d 497 (1999)	Court of Appeals, Second District, Division 6	3c
	Pettus v. Cole, 57 Cal. Rptr.2d 46 (1996)	Court of Appeals, First District, Division 2	1
	Barry v. Turek, 267 Cal. Rptr. 553 (1990)	Court of Appeals, First District, Division 2	3c
	Michael E.L. v. County of San Diego, 228 Cal. Rptr. 139 (1986)	Court of Appeals, Fourth Circuit, Division 1	2
Colorado			
C.R.S.A. § 13-21-117 (1986)	Castaldo v. Stone, 192 F. Supp.2d 1196 (2001)	Federal District Court	3c
	McCarty v. Kaiser-Hill, 15 P.3d 1122 (2000)	Court of Appeals	3b
	Sheron v. Lutheran Medical Center, 18 P.3d 796 (2000)	Court of Appeals	3c
	Halverson v. Pikes Peak Family Counseling and Mental Health Center, 851 P.2d 833 (1992)	Court of Appeals	3b
	Halverson v. Pikes Peak Family Counseling and Mental Health Center, 795 P.2d 1352 (1990)	Court of Appeals	3b
	Perreira v. State, 768 P.2d 1198 (1989)	Supreme Court	1
Delaware			
16 Del.C. § 5402	Shively v. Ken Crest Center for Exceptional Persons, 2001 WL 209910 (2001) (unpublished) (2001)	Superior Court	1
	Bright v. State, 740 A.2d 927 (1999)	Supreme Court	1
	State v. Bright, 683 A.2d 1055 (1996)	Superior Court	1
Florida			
F.S.A. § 456.059 (2000) formerly F.S.A. § 491.0147 (1991)	State v. Famiglietti, 817 So.2d 901 (2002)	Court of Appeals, Fifth District	5
	Guerrier v. State, 811 So.2d 852 (2002)	Court of Appeals, Fifth District	5
	State v. Famiglietti, 817 So.2d 915 (2001)	Court of Appeals, Third District	5
	O'Keefe v. Orea, 731 So.2d 680 (1998)	Court of Appeals, First District	1
	Green v. Ross, 691 So.2d 542 (1997)	Court of Appeals, Second District	4
	Boynton v. Burglass, 590 So.2d 446 (1991)	Court of Appeals, Third District	2
	Santa Cruz v. Northwest Dade Community Health Center, 590 So.2d 444 (1991)	Court of Appeals, Third District	1
Idaho			
I.C. § 6-1901 through 1903 (1991)	Doe v. Garcia, 961 P.2d 1181 (1998)	Supreme Court	1
	Caldwell v. Idaho Youth Ranch, 968 P.2d 215 (1998)	Supreme Court	2
Illinois			
405 ILCS 5/6-103 (1991)	People v. Ranstrom, 710 N.E.2d 61 (1999)	Court of Appeals, First District	5
	Charleston v. Larson, 696 N.E.2d 793 (1998)	Court of Appeals, First District, Division 3	1
	Chapa v. Adams, 1997 WL 414107 (1997)	Federal Northern District of Illinois	4

Table 1 (continued)

State (Statute)	Case (Year)	Court	Approach*
Kentucky			
KRS § 202A.400 (1986)	Riley v. United Health Care of Hardin, 165 F.3d 28 (1998) (unpublished)	Court of Appeals, Sixth Circuit	3e
	Evans v. Morehead Clinic, 749 S.W.2d 696 (1988)	Court of Appeals	2
Louisiana			
LSA-R.S. 9:2800.2 (1986)	Grady v. Riley, 809 So.2d 567 (2002)	Court of Appeals, Fifth Circuit	3c
	Barbarin v. Dudley, 775 So.2d 657 (2000)	Court of Appeals, Fourth Circuit	3d
	Clark v. Baird, 714 So.2d 840 (1998)	Court of Appeals, Fourth Circuit	3c
	Davis v. Puryear, 673 So.2d 1298 (1996)	Court of Appeals, Fourth Circuit	2
	Durapau v. Jenkins, 656 So.2d 1067 (1995)	Court of Appeals, Fifth Circuit	3d
	Hutchinson v. Patel, 637 So.2d 415 (1994)	Supreme Court	2
	In re Viviano, 645 So.2d 1301 (1994)	Court of Appeals, Fourth Circuit	2
	Hines v. Bick, 566 So.2d 455 (1990)	Court of Appeals, Fourth Circuit	3d
	Sayes v. Pilgrim Manor, 536 So.2d 705 (1988)	Court of Appeals, Third Circuit	1
	Sanchez v. State, 506 So.2d 777 (1987)	Court of Appeals, First Circuit	1
Maryland			
Md 5-6 § 5-609 (1989)	Laznovsky v. Laznovsky, 745 A.2d 1054 (2000)	Court of Appeals	5
	Falk v. Southern Maryland Hospital, Inc., 742 A.2d 51 (1999)	Court of Special Appeals	3e
	Hartford Insurance Co. v. Manor Inn, 642 A.23 219 (1994)	Court of Appeals	1
Massachusetts			
MA ST 123 § 36a (1989)	Magee v. U.S., 121 F.3d 1 (1997)	First Circuit Court of Appeals	1
	Carr v. Howard (1996) (unpublished)	Superior Court	3d
Michigan			
M.C.L.A. 330.1946 (1989)	Gragg v. Auburn Counseling Associates, Inc., 2002 WL 1375746 (2002)	Court of Appeals	3c
	Lagow ex. Rel. Estate of Wilson, 2001 WL 936637 (2001)	Court of Appeals	3d
	Johnson v. Hegira Programs, Inc., 1999 WL 33437934 (1999)	Court of Appeals	2
	Richter v. Turlo, 1999 WL 33435417 (1999)	Court of Appeals	3c
	Swan v. Wedgewood Christian Youth & Family Services, Inc., 583 N.W.2d 719 (1998)	Court of Appeals	3d
	Douglas ex rel. Estate of Douglas v. Alpena Gen. Hosp., 1997 WL 33334398 (1997)	Court of Appeals	3c
	Williams ex rel. Estate of Anderson v. Northville Regional Psychiatric Hosp., 1997 WL 33347863 (1997)	Court of Appeals	3d
	Jenks v. Brown, 557 N.W.2d 114 (1996)	Court of Appeals	3d
	People v. Stanaway, 521 N.W.2d 557 (1994)	Court of Appeals	5
	U.S. v. Snelenberger, 24 T.3d 799 (1994)	Sixth Circuit Court of Appeals	5
	Saur v. Probes, 476 N.W.2d 496 (1991)	Court of Appeals	2
	Sellers v. U.S., 870 F.2d 1098 (1989)	Sixth Circuit Court of Appeals	1
Montana			
Mont. Code Ann. § 27-1-1102 (1987)	Lacock v. U.S., 106 F.3d 408 (Table) (1997) (Unpublished)	Court of Appeals, Ninth Circuit	3d
New Hampshire			
N.H. Rev. Stat. Ann. § 329:31 (1994)	Powell v. Catholic Medical Center, 749 A.2d 301 (2000)	Supreme Court	3d
New Jersey			
N.J. Stat. Ann § 2A:62A-17 (West 1991)	Correia v. Sherry 760 A.2d. 1156 (2000)	Superior Court, Law Division, Sussex County	5
	Runyon v. Smith, 749 A.2d 852 (2000)	Supreme Court	5
Tennessee			
Tenn. Code Ann. § 33-3-207 (1989)	U.S. v. Hayes, 227 F.3d 578 (2000)	Court of Appeals, Sixth Circuit	5
	Tabor v. Veterans Administration, ex. rel. U.S., 198 F.3d 247 (1999)	Court of Appeals, Sixth Circuit	3e
	Turner v. Jordan, 957 S.W.2d 815 (1997)	Supreme Court	1
	Hembree v. State, 925 S.W.2d 513 (1996)	Supreme Court	1
Utah			
Utah Code Ann § 78-14a-101 (1988)	Thornock ex rel. Thornock v. Christensen, 2000 WL 33250541 (2000)	Court of Appeals	3d
	Wilson v. Valley Mental Health, 969 P.2d 416 (1998)	Supreme Court	3d
	Higgins v. Salt Lake County, 855 P.2d 231 (1993)	Supreme Court	2
	Rollins v. Peterson, 813 P.2d 1156 (1991)	Supreme Court	1

Table 1 (continued)

State (Statute)	Case (Year)	Court	Approach*
Virginia			
Va. Code Ann.	Head v. Inova Health Services, 2001 WL 1829720 (2001)	Circuit Court	3b
§ 54.1-2400	Walker's Adm. V. Simmons, 2001 WL 1711401 (2001)	Circuit Court	3b
(Michi 1994)	Sage v. U.S., 947 F.Supp. 851 (1997)	Federal Eastern District	1
	Nasser v. Parker, 455 S.E.2d 502 (1995)	Supreme Court	1
Washington			
Wash. Rev. Code § 71.05390 (1987)	State v. Side, 21 P.3d 321 (2001)	Court of Appeals	5
Wash. Rev. Code	Harris v. U.S., 122 F.3d 1071 (1997) (unpublished) (1997)	Court of Appeals Ninth Circuit	1
§ 71.05.120 (1991)	Tobis v. State, 758 P.2d 534 (1988)	Court of Appeals	3c

only. . ." The statute goes on to explain circumstances when one may disclose, including "specificity"-type situations, describes to whom one may disclose, and provides immunity for the disclosure.

The first section implies there is a duty to protect, while the second more permissively allows warning.

The reason qualifying terms such as "appears to" are used, even if the statute's language and intent seem straightforward, becomes evident when court decisions are reviewed. The statutes mean what courts interpret them to mean, even if those interpretations seemingly contradict the language of a statute. Furthermore, if a court does not consider the statute in a case wherein it would seem to apply, the existence of a duty in a practical sense, even if explicitly referenced in a statute, is called into question.

Review of Cases

Today, most states that have enacted a protective disclosure statute have case law regarding the issue. Of the 23 states with protective disclosure statutes, 18 have cases that address potential *Tarasoff* situations (Table 1). As might be expected, given the diverse interpretations by courts across the nation of the mental health provider's duty to third parties prior to such duties becoming statutorily defined, court approaches after statutory enactment are similarly lacking in uniformity. However, these decisions can be categorized into five basic court approaches:

1. Cases not referencing the statute
2. Cases referencing the statute, but not using it in their analysis
3. Cases referencing the statute, using it in their analysis, and finding that it creates a duty,
   a. but finding it unconstitutional
   b. and finding that the facts fell within the statutorily defined circumstances
   c. and finding that the facts did not fall within the statutorily defined circumstances
   d. and finding that the facts did not fall within statutorily defined circumstances, but that there may be/still is a common law duty
   e. and finding the facts fell within statutorily defined circumstances, and the statute abrogates any common law duty.
4. Cases referencing the statute, using it in the analysis, but finding that it does not create a duty
5. Cases referencing the statute in the context of testimonial privilege

1. Cases Not Referencing the Statute

Of the 76 cases included, 21, despite having a potentially applicable protective disclosure statute on the books in the respective state, did not mention the statute even with factual circumstances that would seemingly implicate it (see Table 1 for all cases and their categorization). In some cases, the actual events occurred prior to enactment of the statute. Therefore, one could assume that the statute would not have been applicable, so the court did not address it. However, other courts, even under these circumstances, acknowledged the existence of the statute, but explained that it was inapplicable.[16] In other circumstances, the reason for not referencing the statute is not at all clear. The Appellate Court of Illinois, First District, Third Division, for example, did not mention the statute in a case wherein an inpatient attacked a nurse who subsequently sued the treating psychiatrist for failure to protect her. In finding there to be no protective duty under the circumstances, the court reviewed relevant state case law, and included

an analysis of duty to warn without reviewing either of the Illinois statutes.[17]

2. Cases Referencing the Statute, but Not Using It in Their Analysis

Twelve of the cases fell within this category. In some cases, the courts clarified that the statute was not applicable because the facts occurred prior to the statute's enactment. In other cases, the statute was not considered to be directly on point, although related to the facts. For example, in a Michigan Court of Appeals case in 1999,[18] a suicidal evaluee in a crisis center was assaulted by another evaluee while both were sitting in a waiting room. The evaluating psychiatrist had already determined the second evaluee to be at risk for committing assault. The victim sued for failure to protect. The lower court found that the psychiatrist had discharged any potential duty under Michigan's protective disclosure statute by initiating hospitalization procedures for the assaultive patient. The appellate court found that the lower court should not have applied the statute, but agreed that the psychiatrist was not liable because the defendant did not show any breach of the standard of care under basic malpractice law. The court did not go on to define circumstances under which the statute might be applicable. In another case, the court referenced the statute, but did not clearly indicate why it was not used in its analysis.[19] However, it may have been because the statute applied to "mental health professionals," and the party named in the suit was a facility, not a person.

Thirty-two cases fall within the third category, which has five sub-categories.

3. Cases Referencing the Statute, Using It in Their Analysis, and Finding That It Creates a Duty

a. But Finding It Unconstitutional

Among the cases in this subcategory is one wherein an Arizona appellate court found that the statute was unconstitutional based on a provision of the Arizona constitution.[20] In this case, a wife who was stabbed by her outpatient husband sued the clinic that placed him in an outpatient program rather than hospitalizing him. Initially, the court found the statute to be "the exclusive means of establishing liability in this context" and precluded the claim, because, despite having physically assaulted his wife previously, the patient had never specifically threatened her. In the Arizona constitution, however, there is a provision stating that "the right of action to recover damages for injuries shall never be abrogated, and the amount recovered shall not be subject to any statutory limitation." Because Arizona, under common law, had established a broader duty to protect, the court found the statute to be an unconstitutional abrogation of damage recovery.

b. And Finding That the Facts Fell Within the Statutorily Defined Circumstances

In four cases, the court found the statute to be applicable, relied on the statute in its analysis, found that it created a duty, and found that the facts of the case fell within the statutorily defined circumstances, thereby precluding liability of the mental health care provider. The Colorado Court of Appeals in 2000[21] found a psychologist not to be liable for breach of confidentiality when he informed his patient's supervisors of what he perceived to be threats made toward them by his patient during an early morning phone call. The patient claimed that his statements were not threats. The court applied the statute strictly, finding the statute was intended for just this type of situation, and its immunity provision precluded any liability.

In a Virginia Circuit Court case in 2001 in which a psychiatrist was sued under the protective disclosure statute after he had allowed a weekend visit for a patient who subsequently stabbed to death the five-year-old nephew of the patient's mother whom the patient was visiting, the court found sufficient facts to support potential liability under the statutory provisions. In finding that there was a potential cause of action against the psychiatrist, the court noted that the patient had "communicated. . .on numerous occasions that she intended to seriously injure or kill peers, staff and/or family members." Furthermore, the patient actually had, "on numerous occasions," attacked peers, staff and family members.

The court found that these circumstances met the statutory criteria of a "specific and immediate threat to cause bodily injury or death to an identified or readily identifiable person or persons," despite the seemingly nonspecific nature of the threats that referenced general groups of people.[22]

c. And Finding That the Facts Did Not Fall Within Statutorily Defined Circumstances

The next subcategory includes four cases in which the courts acknowledged the statute, but found that

the facts of the case did not meet statutory requirements. There may not have been specificity, an actual threat, or an identifiable victim, or the actual victim was not the identifiable victim. Applying Louisiana law, the Fourth Circuit Court of Appeals found no liability, because the defendant was not a mental health professional.[23] An elderly woman's primary care physician informed his patient's home health aid that the elderly woman's daughter was mentally ill and violent. After receiving this information, the home health aid decided to leave and was assaulted by the woman's daughter while leaving. The home health aid subsequently sued the primary care physician. Because he was not a mental health professional as defined by the statute, he was not found liable under the statute, but the court suggested that he may have had a "legal duty" not involving the statute.

Another case in this category involves the infamous Columbine High School shootings, when two students brandishing firearms entered the school and proceeded to fire on teachers and students before eventually fatally shooting themselves. Relatives of a slain high school student sued the sheriff's department on multiple counts involving claimed inadequacies of the sheriff's department's response to events prior to the shooting. In its opinion, the court referenced the state's protective disclosure statute as an example of immunity for mental health professionals, except when there is a "serious threat of imminent physical violence against a specific person or persons." It opined that state police officers should not bear the burden of a "higher duty" than that of mental health professionals who "routinely deal with such issues." Furthermore, even if the statute applied to the police, there would be no liability, because the threats made by the assailants were neither imminent nor directed against the actual victims.[24]

d. And Finding That the Facts Did Not Fall Within Statutorily Defined Circumstances, but There May Be/Still Is a Common Law Duty

In 10 cases, the circumstances did not meet statutory requirements, but a common law duty may, or still does, apply. The Supreme Court of New Hampshire in 2000[25] provided an exemplary case. In that case, a stroke patient assaulted a phlebotomist as she was attempting to draw his blood. She claimed the nonpsychiatrist physician owed her a duty to warn. Although the statute did not apply in this case because there was no specific threat to an identified victim, the court found that a common law duty as established by previous case law remained and could sustain a cause of action independent of the statute. A Michigan court of appeals in 2001[26] declined to address whether a common law duty survived enactment of the protective disclosure statute when the facts of the case would not have supported a claim under the statute or common law, because there was no communicated threat.

e. And Finding That the Facts Fell Within Statutorily Defined Circumstances and That the Statute Abrogates Any Common Law Duty

The final subcategory represents perhaps the type of approach mental health professionals had hoped the courts would take regarding protective disclosure statutes. These are cases in which the court recognized, applied, and found the statute to circumscribe the mental health professional's duty to protect. In other words, no "common law" remained after the statute was enacted. Of the three cases in this category, two were decided by the same court, the Sixth Circuit Court of Appeals, a federal court interpreting *Tarasoff* statutes in two different states: Kentucky and Tennessee. In the Sixth Circuit case reviewing the Tennessee statute,[27] an inpatient was released, as he had been on two prior occasions without incident, to testify in a court case in which he was involved. He was staying in a hotel where he had an argument with a hotel security guard, whom the patient had never met before, and fatally shot the security guard with the guard's own gun. The decedent security guard's parents claimed the Veterans Administration Medical Center that released the patient had a duty to warn their victim son of the patient's release. The court focused exclusively on the statute when it found no liability, because the statute required an actual threat against a clearly identified victim. The patient neither threatened nor identified any victim. Similarly, the Sixth Circuit in analyzing the Kentucky statute in a case wherein a 15-year-old patient killed his mother five days after release from inpatient treatment,[28] found that the statute required communication of a specific threat against a reasonably identifiable victim. The teenager never specifically threatened to kill his mother. The court noted that common law, prior to the statute's enactment, had a broader reach, possibly requiring the victim

only to be foreseeable, but the statute superseded common law.

4. Cases Referencing the Statute, Using It in the Analysis, but Finding That It Did Not Create a Duty

One Florida case in 1997 found the state's protective disclosure statute's language to be too "nebulous" to create a duty that could have a tremendous impact on certain social interactions.[29] As mentioned under the review of statutes, the Florida statute was couched in permissive terms.

A 1997 Illinois case involved claims that were based on the plaintiff's losing his job after his psychiatrist warned the plaintiff's employer of the plaintiff's threats against the employer. The court opined that there was no liability, because under the Illinois statute, a therapist is permitted to disclose such information to warn a potential victim.[30] Recall that Illinois has another protective disclosure statute that is conditional rather than permissive and was not mentioned in this case.

5. Cases Referencing the Statute in the Context of Testimonial Privilege

These four cases mention the statute out of a direct duty-to-protect context, but focus on the statute's implications on testimonial privilege. The Sixth Circuit Court of Appeals, applying Tennessee law, decided such a case in 2000.[31] A patient sought to have the testimony of his therapist suppressed in a case against him for making threats to kill a federal official. In finding that there was no exception to psychotherapist-patient privilege in criminal cases, the court merely referenced the statute as an example of an exception allowed in a civil context. The court reasoned that the effect of allowing such an exception in a criminal context would be significantly more chilling to the therapeutic process than in a civil context.

Because these cases actually cite the statutes, they were included in this review. Other, perhaps better known cases, such as the California cases *Menendez v. Superior Court*[32] and *People v. Wharton*,[33] which explored the privilege issue and allowed testimony based on a California rule of evidence and state case law, including *Tarasoff*, were not included, because they did not cite the statute or they did not directly involve a third party suing a mental health professional for failure to warn or protect.

Discussion

Of the five categories of responses presented in this article, the most interesting, or at least unanticipated, were the first category, wherein the statute was not referenced when it, arguably, should have been, and the subsection of the third category, wherein the court found that a common law duty survived any interpretation of the statutory duty. Although both of these particular interpretations were disappointing in helping better define protective duties, analysis of these cases offers some insight into the judicial, legal, and clinical implications of these statutes in general.

Determining the reasons courts seemingly ignore these statutes can only be a speculative exercise. However, possible explanations include the courts' effort to demonstrate their ongoing control over establishing this type of duty despite legislative action; or, as a more benign view, courts simply may not have addressed the statute because lawyers did not reference it in their arguments to the court; or simply because they were not aware of its existence. Another potential explanation for judicial nonconsideration of *Tarasoff* statutes is a conscious disregard of the statutes by both clinicians and trial attorneys. An attorney for the defense in a case that did not reference the statute and an expert psychiatric witness from such a case in a different state both reported that they did not find the statute applicable in their respective cases. Yet, similar fact patterns in other states triggered review of the protective disclosure statute. It seems that the very specificity sought in creating the legislation to define protective duties better has, in at least some instances, precluded the courts' consideration of the statute at all. To what extent are clinicians informed of *Tarasoff* statutes once enacted? To what extent do they deliberately conform protective and confidentiality practices to the *Tarasoff* statute in their state? To what extent do they document their decisions to disclose or not to disclose based on these statutes? When complaints arise concerning failure to warn and protect or failure to maintain confidentiality, do trial attorneys reference the state statutes and use them to support the plaintiff's complaint or to defend the clinician? Conceivably many clinicians and attorneys alike are more familiar with the celebrated *Tarasoff* case itself than with the jurisdictional statutory law. Perhaps more attention to specific statutes at the level of clinical

and legal practice would result in greater regard for these laws by trial and appellate courts.

The other surprising approach was to review the facts not only under the statutory provision, but also the common law. It appears from the cases in this category, that these courts were reluctant to eliminate this cause of action as a means of recovery for victims. The Arizona appellate court salvaged this cause of action by referencing the state's constitution, which did not allow elimination of established causes of action for recovery of damages, but the court could just as easily have accomplished the same result by dichotomizing claims into statutory and common law claims, as other courts did. This judicial attitude is akin to that toward tort reform legislation in the medical malpractice arena. States have attempted tort reform, and a renewed battle, supported by the President of the United States himself, is ongoing in this regard. However, courts have repeatedly viewed this as an impingement on individuals' rights to recover damages for legitimate claims. This attitude in protective disclosure claims is evident even in cases in which the court strictly followed the statutory guidelines, found no liability under the statutory terms, but expressed clear dissatisfaction with this statutorily prescribed result.

If courts either disregard or discount *Tarasoff* statutes, why should policy makers bother? To conclude that legislative efforts to clarify the confidentiality-protection dilemma are hopelessly in vain would be a mistake. Even before the first *Tarasoff* statute, inconsistent and shifting court positions created an amorphous, unstable jurisprudence on the issue.[7,34] Still unmeasured is the extent to which *Tarasoff* statutes serve to standardize practice and to provide guidance at the level of trial courts. This review demonstrates that some courts respect the legislative standard, although in a minority of cases. Nonetheless, policy makers would be well advised to examine discrepant responses of courts to *Tarasoff* statutes as well as relevant state law already established, including the state's constitution when drafting a *Tarasoff* act.

When drafting a potential protective disclosure statute, policy makers should recognize that the specificity of the statute might narrow its application and recognize courts' propensities to protect the victims' access to recompense. A clause defining the scope of the act might alert lawyers and clinicians to the situational applicability of the statute. Such a clause might appear simply as follows: "The following act shall apply when a person is intentionally injured by a mental health patient." In addition, statutes could not only designate when mental health professionals are not responsible, but could allow for circumstances wherein they are responsible due to substandard clinical practice. For example, rather than restricting the clinician's responsibility to act only in situations in which the clinician was aware of a specific threat to a specific victim, extend the clinician's responsibility to include an adequate assessment, when appropriate, to determine the nature and seriousness of the threat. Some statutes have addressed this problem by including a phrase such as "when a psychiatrist knows, or should have known. . . ." This would encourage clinicians to complete more thorough risk evaluations rather than promote less thorough evaluations for fear of discovering a viable threat leading to some potential legal liability. The threat itself should also be qualified to allow for clinical assessment of its authenticity, and if this assessment did not take place, it would be another potential source of liability. Again, some statutes accomplish this qualification by requiring the threat to be likely, based on a reasonable clinical assessment. This type of statute would better define the scope of its applicability, possibly broadening its use; encourage clinicians to complete appropriate evaluations; and gain favor from reviewing courts that would regard the statute as a means of providing reasonable protection to patients, potential victims, and physicians.

Conclusion

Hoping for well-defined limitations of their protective duties, mental health professionals looked to legislatures to provide this structure in statutory form.[9,34] Our review of the case law subsequent to the enactment of such legislation has shown, as previous *Tarasoff* law reviews have suggested,[35] courts have taken diverse approaches in interpreting their state's respective protective disclosure statutes. Only in a small number of cases did courts interpret the statutes to circumscribe the duties owed to third parties. Most, either by ignoring the statute in what seem to be applicable cases or by finding that a common law duty remains independent of it, left the duty to protect ill defined. Because of these approaches, even decisions that suggest the statute does clearly define the duty are dubious precedents when the court does not specifically indicate that the stat-

ute precludes any other claims. There are even cases that seemingly expand the protective duty to non-mental health professional physicians. Although these physicians traditionally have duties to warn others of potentially contagious diseases or disorders that may affect their ability to drive, they have not had a duty to protect others from the intentional violent acts of their patients or their patients' relatives.

Despite the lack of a well-defined duty resulting from *Tarasoff* statutes, clinicians are well advised to be familiar with the statute(s) in their states, and any case law preceding or following enactment(s). To help clinicians identify any trends in a certain state, a table that lists cases, the deciding courts, and the approaches taken by them in each state has been included (Table 1). Adding further to the lack of clarity, other cases, not pertaining to mental health but to liability to third parties in a different context, may also be predictive of a higher court's interpretation of a statute. For example, in Florida, at least two appellate courts have been reluctant to find a protective duty for mental health professionals, given the permissive statute (see Table 1). However, the Florida Supreme Court in *Pate v. Threlkel*[36] imposed a duty to warn of the genetic transferability of a disease and extended the liability for breach of that duty to a patient's children, indicating that the highest state court might be more inclined to find a duty to third parties in a mental health context as well.

In a given situation, a court may take any of several approaches toward the state's protective disclosure statute, including ignoring it, strictly following its terms, or following previous decisions. A psychiatrist may practice in a jurisdiction where courts consistently apply the statute, or where the supreme court of the state has rendered an opinion that cannot be contradicted by lower courts. In these circumstances, a protective duty may be more reliably defined. For most, however, the best course of action is to practice within the proper standard of care and be guided by professional ethics, while maintaining an updated knowledge of the relevant statutory and case law.

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