

# Florida Law Enforcement Policies for and Experience With *Tarasoff*-Like Reporting

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Mandatory duty to warn law enforcement for mental health professionals in Florida took effect on July 1, 2019, as part of the recommendations from the Marjory Stoneman Douglas School (Parkland) Shooting Commission's report. Prior to this, Florida had been a permissive *Tarasoff* state. Although this change was intended to promote public safety, there is scant literature on the interactions between mental health providers and law enforcement related to *Tarasoff* situations. The objective of this study is to determine the degree to which Florida law enforcement agencies have knowledge, experience, and policies dealing with a serious threat made by a patient. An invitation to participate in a survey was distributed to police departments, sheriffs' offices, and 911 stations using email and traditional paper mail. The response rate was 11 percent (47 of 416) to an emailed questionnaire and 22 percent (82 of 369) to a paper-based follow-up survey. The surveys were completed by 31 percent (129 of 416) of potential respondents. Between 80 and 90 percent of all agencies have policies and procedures on what to do if a warning call from a mental health provider is received, which, for the majority of respondents, was the same policy as if notified about a suicidal individual.

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Over the course of their careers, mental health professionals will likely encounter at least one case where concerns arise regarding a patient's potential risk to a third party. The California Supreme Court had issued two significant rulings on this topic, known as *Tarasoff I* in 1974 and *Tarasoff II* in 1976.<sup>1,2</sup> *Tarasoff I* identified a duty for mental health practitioners to warn potential victims.<sup>1</sup> Due to concerns of the impact of the 1974 ruling, the court agreed to revisit their ruling in 1976.<sup>3</sup> In *Tarasoff II*, the California Supreme Court ruled that mental health professionals incur a duty to protect potential victims from serious threats made by patients.<sup>2-8</sup> The court identified the steps of directly warning the victim, calling law enforcement, voluntary hospitalization, or involuntary hospitalization as specific ways for

mental health providers to discharge their responsibility.<sup>2</sup> A potential irony of the *Tarasoff* cases is that a mental health professional actually did issue a warning to law enforcement, both verbally and in writing, with the intention of obtaining a commitment. As noted in the 1976 *Tarasoff* ruling:

[The therapist] orally notified [the Officers] of the campus police that he would request commitment. He then sent a letter to [the Police Chief] requesting the assistance of the police department in securing Poddar's confinement. [The Officers] took Poddar into custody, but, satisfied that Poddar was rational, released him on his promise to stay away from Tatiana (Ref. 2, p 432).

Over the years since these initial rulings, several jurisdictions have expanded the original concept of *Tarasoff* (e.g., foreseeable victims without direct threat), and several jurisdictions placed limitations on *Tarasoff* obligations.<sup>3,4,8</sup> For example, the State of California, where the concept originated, made changes to Civil Code 43.92 as recently as 2013, removing the language of duty to warn.<sup>3</sup>

As seen in the original *Tarasoff* rulings, a clinician's ability to mitigate impending violence is contingent on many outside factors, including, but not

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limited to, law enforcement's readiness and ability to carry out an intervention.<sup>7</sup> In the state of Florida, a mental health practitioner is able to initiate a "Baker Act" or involuntary examination if the individual has been "examined" within the last 48 hours (Florida defines "examination" as the "integration of the physical examination . . . with other diagnostic activities" (Ref. 9, p 57)).<sup>10</sup> Therefore, there may be times when a mental health provider becomes aware of a patient potentially needing an evaluation (e.g., receives a phone message, letter, or e-mail) but is unable to initiate the commitment process unilaterally. It might be a flawed assumption to assume that local law enforcement agencies are well prepared to deal with *Tarasoff*-type warnings of this nature. A 1998–1999 survey of Michigan and North Carolina "desk sergeants" (a supervisory officer at the time of the call) reported that police departments have varying experience with *Tarasoff*-type warnings and almost no knowledge of the actual *Tarasoff* rulings (e.g., only three percent reported knowledge of the case).<sup>11</sup> Despite the fact that almost half of those police stations had received at least one *Tarasoff*-type warning from a mental health provider within the year, only about a quarter of them had policies for handling such warnings.<sup>11</sup> Twenty-seven percent of the stations noted they would not warn a victim, and 20 percent indicated they would not even document the warning from a mental health provider. The authors' conclusion at the time was that, "[b]ecause police apparently have limited experience with *Tarasoff* warnings, calling them may not be the best way to protect potential victims from patients making threats" (Ref. 11, p 807).

A similar phone survey, conducted in 2010 by Kryak<sup>12</sup> (a law enforcement captain), of 18 large Florida law enforcement agencies (i.e., agencies with more than 250 officers) had a 50 percent partial or full response rate. Kryak<sup>12</sup> reported that slightly more than half of responding departments that had officers undergo crisis intervention training actually tracked calls related to mental health crisis. None of the departments surveyed could accurately estimate the number of calls received over the last two years. Every participant who responded believed that crisis-intervention training was beneficial for their department. Kryak noted in his discussion section, "Relying on individual recollections and speculative assumptions produce[d] stochastic results and made it very difficult to report more objectively" (Ref. 12, p 4).

In addition, it is also hard to know how effective *Tarasoff* statutes are in actually reducing violence.<sup>13</sup> Although there are studies comparing the frequency of calls made to law enforcement with the number of involuntary commitments initiated by mental health providers and the responses of potential victims who were warned, to our knowledge there are no studies actually showing a reduction in violence for jurisdiction after initiation of the duty to warn or protect obligations.<sup>14,15</sup> When used appropriately and successfully, there is often little media coverage. There are no identifiable markers to use as measures for population-based outcomes for various reasons: it is impossible to prove prevention on an individual level; violence due to mental illness is a rare event, which makes it difficult to identify, study, and classify; and multiple societal and legal changes occur in any given time period, making determination of a causative factor difficult. We are not aware of any research comparing violence outcomes between states with mandated *Tarasoff* obligations and states that are more permissive on notifying law enforcement or potential victims. Most of the research available regarding varying jurisdictions seems to focus on variations between statutes, case law, and training received by mental health professionals (e.g., most professionals receive some training and education about *Tarasoff* and the resulting obligations, whether practicing in California or elsewhere).<sup>6</sup>

Whenever there is a perceived failure or breakdown related to *Tarasoff* concerns, the media often raise the question of whether more should or could have been done. Examples of this can be seen in states with mandated obligations, such as the 2012 theater shooting in Aurora, Colorado, and the 2014 mass murder in Isla Vista in Santa Barbara County, California.<sup>7,16,17</sup> In both cases, treating mental health providers notified law enforcement of concerns, but there was a perceived lack of imminence to warrant involuntary hospitalization. In the Santa Barbara case, both the perpetrator's mother and a mental health worker had contacted law enforcement asking for a wellness check less than a month prior to the event due to disturbing, but not directly threatening, videos being posted.<sup>18</sup> As noted in the official report of the incident, there was no indication that a negative event was imminent:

Deputies responded to the apartment where the suspect was believed to be home alone. They interviewed him and, as they are trained to do in routine "check the welfare"

**Table 1** Portion of Florida Statute 456.059: Communications Confidential; Exceptions

Language Prior to 2019	Language in effect after June 1, 2019
The psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency. No civil or criminal action shall be instituted, and there shall be no liability on account of disclosure of otherwise confidential communications by a psychiatrist in disclosing a threat pursuant to this section.	(2) Such patient has communicated to the psychiatrist a specific threat to cause serious bodily injury or death to an identified or a readily available person; and (3) The treating psychiatrist makes a clinical judgment that the patient has the apparent intent and ability to imminently or immediately carry out such threat, the psychiatrist 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.

From References 19 and 20. Similar language for other mental health care practitioners is codified in different regulator statute sections.

calls, they assessed the situation. Deputies found the suspect to be shy, timid, and polite. When deputies asked about the videos he was said to have posted, but which the deputies had not viewed, the suspect explained he was having trouble fitting in socially in Isla Vista. The videos were merely a way of expressing himself. There was nothing during the contact with the suspect that gave deputies reason to believe he was a danger to himself or others . . . . The entire contact with the suspect on April 30th lasted approximately 20 minutes (Ref. 18, pp 47–48).

Even with the actions taken by the police and the mental health provider at the time, headlines such as “Santa Barbara Rampage Spotlights Therapists’ ‘Duty to Protect’: California law requires therapists to notify police of violent threats” still occurred in the aftermath of the event.<sup>17</sup>

Florida has traditionally been one of the states that had a permissive *Tarasoff*-like statute for notifying both potential victims and law enforcement when, in the clinical judgment of the psychiatrist, “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.”<sup>19</sup> This changed in the wake of the 2018 Parkland school shooting, with new legislation that took effect July 1, 2019 (see Table 1).<sup>20</sup> The current Florida statutes require mental health professionals to contact law enforcement, but still maintains a permissive element for contacting the potential victim directly. The Parkland report also revealed limitations in certain law enforcement agencies’ preparedness to respond to threats, such as the Broward County Sheriff’s Office reportedly lacking adequate training for active-shooter situations.<sup>21</sup> In contrast, in Coral Springs, a city in Broward County, police officers were found to have a good knowledge of active-shooter policy because they attended the training on an annual basis.<sup>21</sup> This highlights how law enforcement, even in similar geographic locations and under the same state laws, can

have varying policies, education, and responses to a dangerous-person scenario.

The objective of this study, in light of the changes brought about by the Parkland school shooting and other publicized events, was to determine the degree to which Florida law enforcement agencies have policies, knowledge, or experience dealing with contacts from mental health providers regarding a threat made by a patient toward an identifiable victim or location.

**Methods**

In June 2019, a survey was distributed via e-mail to all law enforcement agencies that were identified by publicly available lists in the state of Florida.<sup>22–24</sup> In total, 416 Florida law enforcement agencies, including 285 police departments, 66 sheriffs’ offices, and 65 emergency 911 call centers were contacted. A follow-up electronic survey reminder was sent two weeks later. An additional paper survey was mailed to those agencies that did not respond to the electronic mailing after 30 days because we had received feedback that some agencies did not respond to electronic requests regarding policy.

Statisticians were consulted to determine the statistical tests to perform and the number of responses needed for adequate power to be obtained. Statistical data analysis was performed to compare the three types of Florida law enforcement agencies. Between-group comparisons were conducted using analysis of variance for continuous variables and the Pearson chi-square test for categorical variables. All tests were two-sided, and *p* values < .05 were considered statistically significant. Data were analyzed with SPSS Statistics 24.0 (IBM Corp., Armonk, New York). Study data were collected and managed using the Qualtrics Research Suite hosted at the University of Central Florida.

## Florida Law Enforcement Experience With Tarasoff-Like Reporting

**Table 2** Experience With *Tarasoff* Warnings Among Florida Law Enforcement Agencies

Question	Total n = 129	Police n = 91	Sheriff n = 29	911 n = 9	p
1 Agency has a policy and/or procedure on what to do if a mental health provider calls in expressing concern about a patient making a threat towards others but not a threat towards themselves.	107 (82.9)	74 (81.3)	26 (89.6)	7 (77.8)	.532
1a This policy or procedure is the same as if the patient was expressing a threat to harm just themselves.	88 (68.2)	65 (71.4)	19 (65.5)	4 (44.4)	.180
2 The information is disseminated to the general law enforcement officers on duty if a warning is received.	119 (92.3)	85 (93.4)	26 (89.6)	8 (88.9)	.746
2a The warning is transmitted to the next shift within a 24-hour period.	112 (86.8)	80 (87.9)	25 (86.2)	7 (77.8)	.867
2b The warning is disseminated to a specific unit or active officer.	8 (6.2)	4 (4.4)	3 (10.3)	1 (11.1)	.643
3 Agency has a policy or procedure to notify a potential victim if a specific victim is identifiable.	115 (89.1)	82 (90.1)	24 (82.7)	9 (100.0)	.300
4 Agency has a policy or procedure to notify a locational authority (e.g., management) if no specific individual is threatened but a general location is identified in a threat (e.g., workplace, school, entertainment venue).	118 (91.4)	81 (89.0)	28 (96.5)	9 (100.0)	.634
5 Agency has a policy or procedure to monitor a potential victim if a specific individual is identified.	77 (59.6)	54 (59.3)	16 (55.2)	7 (77.8)	.478
6 Agency has a policy or procedure to monitor a potential location if a specific location is identified.	104 (80.6)	74 (81.3)	22 (75.9)	8 (88.9)	.848
7. Agency has a policy or procedure to document a warning call from a mental health provider.	116 (89.9)	82 (90.1)	27 (93.1)	7 (77.8)	.408
8. Agency has a policy or procedure to notify a state body for additional action or information tracking purposes when a mental health provider calls (e.g., the Florida Department of Law Enforcement).	38 (29.5)	28 (30.7)	8 (27.6)	2 (25.0)	.404
9. Officer responding to this survey has knowledge or education regarding the court case/ruling known as <i>Tarasoff</i> .	56 (43.4)	37 (40.6)	17 (58.6)	2 (22.2)	.002*
9a. Officer has a good functional/working understanding of the <i>Tarasoff</i> case.	48 (37.2)	32 (35.2)	15 (51.7)	1 (11.1)	.335

Data are presented as n (%).

\*  $p < .05$ .

**Table 3** Frequency of Receiving a *Tarasoff* Warning From a Mental Health Provider by Florida Law Enforcement Agencies

Question 10	Total n = 74	Police n = 58	Sheriff n = 13	911 n = 3	p
How many times in the last year agency received a warning from a mental health provider regarding a patient threatening other(s).	2.8 ± 7.2	1.7 ± 4.7	6.5 ± 13.6	6.7 ± 4.2	.058

Data are presented as mean ± SD.

Any additional information received from Florida law enforcement agencies was recorded. One agency explained the reason for not being able to participate in the survey as being prohibited from releasing policy or information related to activities within its territory. One police department left a note indicating that they contract with a local sheriff's office that can provide more accurate information regarding incoming threats. One envelope was returned without reaching its intended destination, possibly due to delivery problems or change of address.

This study did not attempt to distinguish respondents based on size of department, funding, or population size served. To encourage participation, recipients were informed that results

would be reported in the aggregate, with no identifying information for any one department or location being reported or broken out. The study was deemed to be exempt from institutional review board approval by the authors' institutional board because it was a policy study.

### Results

Results are summarized in Table 2, Table 3, and Table 4. Eleven percent (47 of 416) of Florida law enforcement agencies completed the online survey. Response rate to paper-based invitations was 22 percent (82 of 369). The final total response rate was 31 percent (129 of 416). Based on the power analysis and consultation with a statistician, a response rate of

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**Table 4** Written Comments on Mailed Paper-Based Questionnaire

Question	Comments
1 Agency has a policy and/or procedure on what to do if a mental health provider calls in expressing concern about a patient making a threat towards others but not a threat towards themselves.	<p>“Our PD does not have a specific policy regarding a mental health provider calling. However, a threat is a crime and handled as such through other policies/procedures. This could be handled as a Baker Act situation and/or criminal in nature, due to the threat made.”</p> <p>“While our PD doesn’t specifically address a mental health provider’s calling in regarding concerns about a patient who may be making threats towards others, it does provide general guidelines that would apply in such a scenario.”</p> <p>“Handling on case by case basis reviewed by Sheriff and staff.” (Sheriff’s office)</p>
1a This policy or procedure is the same as if the patient was expressing a threat to harm just themselves.	“Our Baker Act policy is separate stand-alone policy. Threats against oneself are addressed under that policy.” (PD)
2 The information is disseminated to the general law enforcement officers on duty if a warning is received.	<p>“Yes, it would be disseminated through internal be-on-the-lookout (BOLO) bulletins and messaging systems. It would also be provided to the Intelligence Unit.” (Sheriff’s office)</p> <p>“Dependent on the nature of the threat and the ability of the subject to carry out the threat.” (Sheriff’s office)</p>
2a The warning is transmitted to the next shift within a 24-hour period.	No comments
2b The warning is disseminated to a specific unit or active officer.	No comments
3 Agency has a policy or procedure to notify a potential victim if a specific victim is identifiable.	<p>“The policy doesn’t specifically address that set of circumstances; however, our practices have always been to forward such information to a patrol deputy or Intelligence Unit detective for follow-up. Contact would be made with the potential victim.” (Sheriff’s office)</p> <p>“Dependent on the nature of the threat and the ability of the subject to carry out the threat.” (Sheriff’s office)</p>
4 Agency has a policy or procedure to notify a locational authority (e.g., management) if no specific individual is threatened but a general location is identified in a threat (e.g., workplace, school, entertainment venue).	No comments
5 Agency has a policy or procedure to monitor a potential victim if a specific individual is identified.	“That decision is made on a case-by-case basis, depending largely upon what information we have at the time and what is considered to be in the best interest of a potential victim.” (Sheriff’s office)
6 Agency has a policy or procedure to monitor a potential location if a specific location is identified.	<p>“That decision is made on a case-by-case basis, depending largely upon what information we have at the time.” (Sheriff’s office)</p> <p>“Depends” (Sheriff’s office)</p>
7. Agency has a policy or procedure to document a warning call from a mental health provider.	“All cases are documented in our computer-aided dispatch system.” (Sheriff’s office)
8. Agency has a policy or procedure to notify a state body for additional action or information tracking purposes when a mental health provider calls (e.g., the Florida Department of Law Enforcement).	<p>“Dependent upon the type of threat and potential for carrying out same . . . situational awareness would be disseminated to the PD within the region.” (PD)</p> <p>“That would be determined on a case-by-case basis.” (Sheriff’s office)</p> <p>“Depends on the threat and credibility.” (PD)</p> <p>“Depends” (Sheriff’s office)</p>
9. Officer responding to this survey has knowledge or education regarding the court case/ruling known as <i>Tarasoff</i> .	No comments
9a. Officer has a good functional/working understanding of the <i>Tarasoff</i> case.	No comments
10. How many times in the last year agency received a warning from a mental health provider regarding a patient threatening other(s).	<p>“Seven cases approximately, we do not keep specific statistics on these cases. It includes two threats that came in from mental health providers for school students.” (Sheriff’s office)</p> <p>“No easy way to distinguish.” (PD)</p> <p>“Unknown” (Sheriff’s office)</p>

PD = police department.

at least 26 percent was seen as the minimum number required given the type I error probability of 0.05 to obtain a power of 0.8.

No difference was found among responses received from the three types of agencies for eight of the yes-or-no questions and three yes-or-no sub-



questions on whether they have certain policies or procedures about dealing with *Tarasoff*-type warnings (Table 2). About 90 percent of agencies indicated that they have a policy or procedure to notify a potential victim if a specific victim is identifiable and to notify a location authority (e.g., management, administration) if a general location is identified (e.g., workplace, school). About 90 percent would document a warning call from a mental health provider and disseminate information to general law enforcement officers on duty.

About two thirds of the departments reported having the same response policy for a patient threatening to harm others as they do for threatening to harm self. About two thirds of agencies also have policy or procedure to monitor a potential victim if a specific individual is identified. Only about one third of agencies have a policy or procedure to notify a state body (e.g., Florida Department of Law Enforcement) for additional action or informational tracking purposes after receiving calls from mental health providers.

There was a statistical significance ( $p = .002$ ) among the three types of agencies in whether an officer responding to the survey had any knowledge or education regarding the court case or ruling known as *Tarasoff* (Question 9). Almost half of police departments (40%) and sheriffs' offices (56%) reported knowing about *Tarasoff*, and about 1 in 5 (20%) of the 911 stations responded "Yes" to this question.

No difference was found among responses received from the types of agencies to Question 10 about the number of times their agency had received a warning from a mental health provider regarding a patient threatening other(s) in the last year (Table 3). The high standard deviations in answers indicate that there is a large range in the number of times the agencies received *Tarasoff* warnings. It could also be due to respondents approximating their answers without verifying the true number documented on file. This possibility was supported by various comments that were written on returned paper surveys next to Question 10 (Table 4), such as "lots," "2 to 4," "less than 5," "depends," "unknown," and others.

## Discussion

To our knowledge, this is the first study to evaluate the presence of policy, knowledge, or experience with *Tarasoff*-type warnings coming from mental

health professionals to Florida law enforcement agencies. The encouraging news is that most law enforcement agencies who responded had policies in place to address *Tarasoff* concerns. Given that the survey was brief to encourage participation, the specifics of the policies are not fully known, and, given some of the responses received from departments, specifics on policies may not have been shared even with more direct and expansive inquiries. One key element that was identified is that the majority of the policies are similar to, if not the same as, how a department would respond to a call regarding a patient expressing self-harm (68%). This observation raises the question of whether unique policies and procedure are needed for explicit *Tarasoff* situations, such as a criminal background check for every *Tarasoff*-type call as part of the risk assessment for the officers, more in-depth domestic violence screening of significant others living with the individual, or follow-up contact with a treatment provider if one is known. A 1998 study by McNeil and colleagues<sup>15</sup> examining characteristics of individuals about whom *Tarasoff* warning calls were made by mental health care providers to the police indicated that over 50 percent of the patients had a criminal history; the majority had made threats against a family member, friend, or a former partner; and 52 percent were civilly committed. Although this study is older, it does highlight that about 50 percent of patients about whom a mental health care provider had concerns, and theoretically was not in a position to civilly commit, were not detained after the warning.

What also became evident with the results of our survey is that there is a lack of uniformity in centralized data processing, at least among the respondents. Whereas 90 percent of respondents would document a call from a mental health provider, only 38 percent of agencies pass the information to a centralized hub. Although the documentation and response rate seem much improved from the earlier studies discussed,<sup>11,12</sup> this lack of centralized collection of data may hinder the formation of sound public policy and implementation of surveillance measures (e.g., improved mental health care funding, training for law enforcement and mental health care providers, or targeted mental health interventions for certain populations). The lack of centralized data from law enforcement also makes it difficult to determine metrics to track the frequency and outcomes of these calls on a state level and to compare one state's approach to another's.

Most agencies that responded have policies regarding notifying the potential victim (89.1%) or locations (91.4%). This finding is important information for psychiatrists and policy makers to be aware of. Given that law enforcement has more resources and capacity to identify potential victims' contact information (e.g., driver's license databases) than mental health providers in general, it seems appropriate to delegate notification to the law enforcement community. In addition, law enforcement may be better able to answer potential victims' questions on how to handle or address the situation, such as what will be done, how to protect oneself, and legal options (e.g., how to obtain a restraining order or initiate a trespass complaint). It was also important to learn that 59.6 percent and 80.6 percent of departments had policies about monitoring a suspected victim or location, respectively, which indicates that notifying law enforcement did have positive value for safety to the threatened person or location beyond just notifying potential victims.

Although many agencies said they had policies in place and would document calls that come in, there was difficulty gauging how many of these warnings the departments received in a year. The only free-answer question (i.e., the number of *Tarasoff* calls an agency received in the preceding year) was the most frequently unanswered question. Those who did provide numbers reported few if any known calls (< 10), as indicated by the mean  $\pm$  SD being  $2.8 \pm 7.8$ . It is important to note that this relatively low number of calls occurred when Florida was still primarily a permissive *Tarasoff* state. The authors hope to follow up in the coming years to determine if the change from permissive to mandatory reporting will have an impact on this number.

Similar to the study by Huber et al<sup>11</sup> in North Carolina and Michigan, a minority of law enforcement respondents (43.4%) had knowledge, education, or experience with the *Tarasoff* ruling. One could argue that this finding is not surprising because *Tarasoff* is a court ruling that is only applicable in California. But most mental health providers are trained on the duty and obligations that have resulted from *Tarasoff* and the majority of states have a *Tarasoff*-type legal obligation.<sup>6</sup> For the average mental health provider, *Tarasoff* has become the shorthand way to refer to the duty or obligation to keep a third party safe. The fact that past researchers thought that law enforcement in different jurisdictions should

know about a decades-old California court case highlights the potential communication problem that may exist between mental health providers and law enforcement. Mental health providers may know the duty and obligation, but not the fine points of the legal system<sup>6</sup>; similarly, law enforcement may be well versed in their jurisdiction's laws but unaware of the duty or expectations of outside professions.

The Florida statute was intentionally written to require a treatment provider to notify law enforcement without specifying which law enforcement agency (i.e., the agency where treatment is provided, where the patient lives, or where the potential victim lives). In part, this was done to decrease the burden on the care provider (e.g., one call rather than three; not having to decide which agency to call). In Florida, it can be as simple as the provider dialing 911, with the assumption being that the dispatcher would better know which law enforcement agency or agencies should respond, how to contact them, and what information law enforcement would need to know to make the wellness check and to contact the potential victim or location.

As to specifics of education that may benefit law enforcement in the state of Florida, that may vary depending on the situation and resources of each department. For example, 34 Florida sheriff's departments had special Crisis Intervention Team (CIT) officers in 2014, and it is estimated that more than 3,000 law enforcement individuals had received CIT training by 2015.<sup>25,26</sup> There have been attempts to increase the number of counties participating, with the state allocating additional funds for counties not already participating.<sup>25</sup> We are not aware of how many police departments in the state of Florida have undergone CIT training, although it is known that some larger metropolitan departments have done so. The CIT training program involves at least 40 hours of additional training designed to help law enforcement and other first responders effectively render services to individuals with mental illness.<sup>25-28</sup> The Florida CIT training program includes education about mental health symptoms, risk assessment for self-harm and violence, de-escalation techniques, and resource utilization (e.g., follow-up with family, case workers, and facilitating contact with crisis intervention units if needed).<sup>27</sup> There is abbreviated CIT training available for dispatchers, but we have no data about how many dispatchers have participated in this program or how the training is modified.<sup>27</sup>

Although the official Florida CIT program model does not specifically make reference to *Tarasoff*, the fact that this training is available and has been utilized by at least half of the Florida sheriff's departments may indicate why the sheriffs' offices had the highest familiarity rate with the *Tarasoff* ruling and the concepts it incorporates.

One complaint that many health care providers voice when dealing with a *Tarasoff* situation is the lack of feedback related to outcome from a law enforcement perspective. As noted in some of the anecdotal examples above, such as the 2014 mass murder in Isla Vista, law enforcement identified that there was no imminent risk, so they did not feel they were able to initiate an involuntary commitment process at the time.<sup>18</sup> As noted in the official report on the incident, the police talked with the perpetrator's mother but did not provide any feedback or have a discussion with the mental health counselor, who also called in about a month before the event. This is the description of the interaction in the report:

After [the Officers] were finished speaking with the suspect, one of the deputies called [the mother] and briefed her on the situation. The deputy asked [the mother] if the YouTube videos she watched were suicidal or homicidal in nature. [The Mother] said they were not . . . . At the end of the conversation, the deputy asked [the mother] if she needed further assistance, or if there was anything else that needed to be done. [The Mother] did not request any follow-up action (Ref. 18, p 47).

Without suggesting that the officers were at fault or did anything wrong in this case, this is an example where feedback or additional discussion with the mental health provider who had called in might have resulted in a different outcome (e.g., more frequent visits or change in therapeutic approach, better therapeutic interaction due to outside collateral information, deeper assessment of potential risk at next visit). California did make changes in aspects of its laws related to wellness checks after this event, such as giving law enforcement more discretion to confiscate weapons.<sup>18</sup> An additional change that may be considered in the future, especially regarding individuals with a known mental health history who are in active treatment, is for law enforcement to contact the treater about the outcome.

Although an increased level of communication between law enforcement and treaters for the purpose of patient and public safety can have potential benefits, there is also the prospect of additional ethics

concerns (e.g., confidentiality) or legal concerns (e.g., HIPAA). Although a full discussion of these areas is beyond the scope of this article (e.g., dangerous-patient exception, emergency exceptions), a brief discussion is warranted. The American Psychiatric Association's ethics guidelines note, "Psychiatrists should not provide third parties with more information than is needed under the circumstances and they should stick to the facts" (Ref. 29, p 5). Adhering to this guidance may be challenging when it comes to interactions with law enforcement where it may be difficult to identify what information is relevant (e.g., potential marital or sexual problems leading to patient stress if the suspected threat is to the general public or workplace). Most states have laws that allow for clinicians to provide information in good faith when there is concern of serious risk to third parties based on clinical judgment. In addition, emergent or dangerous situations are exceptions to HIPAA.<sup>30</sup>

Although there are concerns related to the provider's giving out information, there are usually no concerns about their receiving factual outside collateral information. If law enforcement officers are able to identify a mental health provider from the original call or learned from the patient, then it might be important for future policies or statutes to allow feedback from law enforcement to treaters as part of a *Tarasoff* or wellness call situation. Receiving factual information that a safety check has occurred, the context of the interaction, and the outcome would likely aid the clinician in providing follow-up care.

The new Florida statute mandates notice to law enforcement but is permissive for notification to a potential victim. This requirement makes it difficult to predict the law's effect on the frequency with which providers will try to call potential victims in the future. Considering the state was permissive before and remains permissive after, it may have no effect. It could result in increased attempts to call because providers may make the erroneous assumption that the new statute is mandatory in all areas. It could also lead to a decreased number of calls because the provider may feel confident that law enforcement has been notified and, therefore, the potential victim will be notified through law enforcement. An older study looking at potential victims contacted regarding threats from patients indicated that most individuals were already aware of the threat and were perceived as



having “anxiety mixed with thankfulness” for being contacted (Ref. 14, p 1212).

We also note that more than half of surveyed agencies did not participate in this survey even when invited to do so by varying means and multiple invitations. Those who did participate preferred answering a paper questionnaire and mailing it back over filling out an online survey. Although this finding was somewhat unexpected, it is important information for those who plan to conduct future research on the topic. Therefore, when considering any future surveys among law enforcement agencies, it would be advisable to include both paper- and web-based questionnaire invitations.

### Limitations

A limitation of this study is the response rate (11% to web-based questionnaire and 20% to follow-up paper-based questionnaires). These response rates are lower than what are commonly seen in e-mail or mailed surveys, which is usually 20 to 47 percent.<sup>31</sup> We note that a 2008 law enforcement–initiated e-mail survey of Florida law enforcement departments posted on the Florida Department of Law Enforcement website related to CIT refresher training had only a 13 percent response rate.<sup>32</sup> So, although the response rate for this survey of law enforcement agencies appears low compared with other groups (e.g., educational surveys), it is actually in keeping with past attempts to survey the Florida law enforcement population. Considering that both paper and electronic means were used and very few mailed surveys were returned as undeliverable, it is not clear why the rate was so low. A possible explanation was that, given the recent change in the state statutes, many agencies may have been updating or drafting policies and simply chose not to respond because their agency was in a state of transition. Another possible explanation is that, given the changes in the laws and the factors that brought it about, some agencies may have seen the questionnaire as potentially too political and therefore chose not to respond.

The participation rate could have potentially been higher if surveys were completed via telephone or in-person interviews. Such interviews have greater potential for bias associated with interviewer pressure (e.g., tone of voice of interviewer may influence responses, or a law enforcement officer may want to look better when responding in an interactive situation). Also, it was hoped that e-mail and mail surveys

would lead to the most accurate information being collected because it would allow respondents time to look up or confirm information before responding if they wanted to.

Another limitation of this study is not being able to account for responses of those agencies that did not participate in the survey, potentially leading to nonresponse bias. It is impossible to predict whether agencies that were unwilling or unable to respond have any policy, knowledge, or experience about dealing with contacts from mental health care providers. Therefore, information reported in this study should be viewed as a best-case scenario.

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