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Tarasoff as a Duty to Treat: Insights From Criminal Law

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TARASOFF AS A DUTY TO TREAT: INSIGHTS FROM CRIMINAL LAW

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INTRODUCTION

At the beginning of its fourth decade the holding in *Tarasoff v. Regents of the University of California*,[1] requiring mental health professionals to take reasonable steps to prevent violence threatened by their patients, seems to have stood the test of time. When the *Tarasoff* decision was first handed down, opponents predicted that the decision would lead to unwarranted hospitalizations and ineffectual phone calls to police and victims, at the same time it would *increase* the public peril because wary therapists would avoid potentially violent individuals, who in turn would be reluctant to talk about violent thoughts or to enter therapy in the first place.[2] Empirical research, conducted within the first decade of *Tarasoff's* existence, lent some credence to those claims.[3] Yet a recent review concluded that, narrowed down to a requirement that therapists act on patient threats of serious harm to identified victims,[4] the

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1. 551 P.2d 334 (Cal. 1976). The California Supreme Court's initial decision in the case is at 529 P.2d 553 (Cal. 1974), but a rehearing was granted and the holding described in the text is from the second decision.

2. One of the first, and arguably the best, criticisms of *Tarasoff* along these lines is found in Alan A. Stone, *The* Tarasoff *Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976).

3. *See* David J. Givelber et al., Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443, 467 (about one-third of surveyed therapists were more willing to initiate involuntary hospitalization after *Tarasoff*); Toni Pryor Wise, Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 177 nn.67, 86, & 181 (1978) (finding that, post-*Tarasoff*, nearly 25% of therapists noted patients' increased reluctance to discuss violent thoughts and a small minority rejected patients considered dangerous); David L. Rosenhan et al., *Warning Third Parties: The Ripple Effects of* Tarasoff, 24 PAC. L. J. 1165, 1214 nn. 245, 1215 table 10 (1993) (60% of therapists surveyed felt that patients were at least "somewhat" more reluctant to divulge sensitive information, 26.3% reported they had lost patients who were informed of the *Tarasoff* requirement "at the outset of therapy", and 50.2% reported losing patients who made a threat and were told of the possible need to breach confidentiality).

4. Most states today only impose "*Tarasoff* liability" if the victim is identified or identifiable. *See* Allison L. Almason, Comment, *Personal Liability Implications of the Duty to Warn are Hard Pills to Swallow: From* Tarasoff *to* Hutchinson v. Patel *and Beyond*, 13 J. CONTEMP. HEALTH L. & POL'Y 471, 478 n. 47 (1997). A few courts reject these limitations. *See, e.g.*, Hamman v. County of Maricopa,

Tarasoff duty "might hold more potential for good than once was believed."[5] Numerous other commentators have also concluded that *Tarasoff* isn't so bad after all.[6] Even those who initially vehemently criticized *Tarasoff* have backed off from that position.[7]

That conclusion does not mean that *Tarasoff* is without flaws, of course. At the margins, the *Tarasoff* rule undoubtedly leads to unnecessary breaches of confidentiality and hospital commitments, reticence about taking on problem patients, more tension between doctor and patient because of an increased focus on dangerousness, and more stress among therapists who know they are not particularly good at assessing risk. We also do not really know the answer to the key policy question underlying *Tarasoff*: whether the duty announced in that case reduces the number of serious violent incidents by patients, when compared to a regime where ethics and sound treatment practices, rather than civil liability, provide the primary incentive to prevent harm.[8] For these types of reasons, many jurisdictions have rejected *Tarasoff*.[9] At best, we can only say that, in those jurisdictions where it applies, and probably even in those jurisdictions where it does not, the *Tarasoff* rule has made therapists more careful in their treatment of potentially violent individuals.[10]

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775 P.2d 1122, 1128 (Ariz. 1989); Schuster v. Altenberg, 424 N.W.2d 159, 166 (Wis. 1988).

5. *See* Brian Ginsburg, Tarasoff *at Thirty: Victim's Knowledge Shrinks the Psychotherapist's Duty to Warn and Protect*, 21 J. CONTEMP. HEALTH L. & POL'Y 1, 2 (2004).

6. *See* Paul S. Appelbaum, *Implications of* Tarasoff *for Clinical Practice*, *in* THE POTENTIALLY VIOLENT PATIENT AND THE *TARASOFF* DECISION IN PSYCHIATRIC PRACTICE 94 (James Beck ed., 1985) ("[C]linicians have learned to live with *Tarasoff*, recognizing that good common sense, sound clinical practice, careful documentation, and a genuine concern for their patients, are almost always sufficient to fulfill their legal obligations."); Lawson R. Wulsin et al., *Unexpected Clinical Features of the* Tarasoff *Decision: The Therapeutic Alliance and the "Duty to Warn,"* 140 AM. J. PSYCHIATRY 601 (1983) (reporting instances where warnings have furthered the therapeutic alliance and contributed to a patient's progress in therapy); James S. Beck, *When a Patient Threatens Violence: An Empirical Study of Clinical Practice After* Tarasoff, 10 BULL. AM. ACAD. PSYCHIATRY & L. 189, 199 (1982) (finding that *Tarasoff* "seldom had an adverse effect on the therapeutic relationship" if warnings requirement is discussed openly with patient).

7. *See* ALAN A. STONE, LAW, PSYCHIATRY, AND MORALITY 181 (1984) ("the duty to warn is not as unmitigated a disaster for the enterprise of psychotherapy as it once seemed to critics like myself.").

8. Michael L. Perlin, Tarasoff *and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 L. & PSYCHOL. REV. 29, 60 (1992) ("there is no reliable database of empirical evidence as to the therapeutic value of *Tarasoff* warnings or of the case's ultimate 'real life' impact.").

9. *See, e.g.*, Thapar v. Zezulka, 994 S.W.2d 635, 636 (Tex. 1999); Gregory v. Kilbride, 565 S.E.2d 685, 692 (N.C. Ct. App. 2002); Nasser v. Parker, 455 S.E.2d 502, 506 (Va. 1995); Boynton v. Burglass, 590 So.2d 446, 447 (Fla. Ct. App. 1991).

10. Fillmore Buckner & Marvin Firestone, *"Where the Public Peril Begins" 25 Years After* Tarasoff, 21 J. LEGAL MED. 187, 214 (2000) ("Ultimately, *Tarasoff* has stimulated greater awareness of the violent patient's potential for acting out such behavior, encouraging closer scrutiny and better documentation of the therapist's examination of this issue.").

The purpose of this paper is not to rehash these issues, all of which have been diligently discussed.[11] Rather, the focus here will be an analysis of *Tarasoff's* potential impact outside of tort law and on groups other than the mental health profession. That focus raises questions about the case that, despite the voluminous commentary about it, have not been raised before, or at least not as explicitly.

The main vehicle for carrying out this project will be the *criminal* law. A good case can be made for the proposition that a breach of the *Tarasoff* duty, as defined today, should lead to criminal, as well as civil, liability, not just for something minor like a failure to report a potential crime, but for the felony committed by the patient. A somewhat weaker argument can be made that this criminal liability should extend beyond mental health professionals to other professionals, such as lawyers, and to the public at large. It is in exploring whether these assertions are sustainable that I hope to expose some important, heretofore little noticed, features of the *Tarasoff* duty and suggest some limitations on it.

The ultimate conclusion one might reach based on this way of looking at *Tarasoff* is that, if some type of duty regarding dangerous people is to be imposed on mental health professionals—as distinguished from the rest of society—it should be conceptualized as a duty to treat dangerousness, not as an omnibus duty to prevent harm to third parties. As a practical matter, this duty would most likely result in liability (civil and criminal) when a mental health professional: (1) knows that a patient has threatened an identified person with serious bodily harm; (2) knows that the patient has engaged in conduct aimed at achieving that end; and (3) fails to commit or otherwise treat the patient in a manner calculated to alleviate the danger. In short, a mental health professional in a *Tarasoff* situation should have a duty to treat but should never have a duty to warn the potential victim or call the police, unless we are also prepared to make non-clinicians equally liable, civilly and criminally, for failing to take such steps under the same conditions.

I. *TARASOFF'S* RELATIONSHIP TO CRIMINAL LIABILITY

To my knowledge, no jurisdiction has criminally prosecuted a mental health professional for a violation of *Tarasoff*. That does not mean such prosecutions would be inappropriate under all circumstances, however. A clinician who breaches *Tarasoff* might easily be found criminally liable under current doctrine, especially if a violation of *Tarasoff* is

11. In addition to the articles cited in the previous notes, *see* Peter F. Lake, *Revisiting* Tarasoff, 58 ALB. L. REV. 97 (1994); Vanessa Merton, *Confidentiality and the "Dangerous" Patient: Implications of* Tarasoff *for Psychiatrists and Lawyers*, 31 EMORY L.J. 263 (1982).

defined as a failure to take preventive steps after a patient has threatened serious bodily harm to an identifiable victim.

In criminal law, as well as tort law, there is no general duty to rescue people from trouble, much less prevent it.[12] Thus, it is usually not a crime to watch a person drown, or to fail to alert a potential victim that someone is intent on killing them. As described in more detail below, in most jurisdictions even failure to report a crime one has observed is not a crime.

However, it is well-established that a failure to act can form the predicate for criminal liability if the failure constitutes a violation of a recognized legal duty.[13] That duty can be created by relationship, statute, caselaw, or contract.[14] Thus, a lifeguard may be guilty of manslaughter if he or she fails to save a drowning person, and parents and guardians can be guilty of homicide if they neglect to feed children in their care.[15] More relevant to the present discussion, parents and employers have been found criminally liable, even for homicide, when they did not protect third parties from their children and employees, respectively.[16]

The *Tarasoff* decision imposes the same type of duty on mental health professionals toward third parties threatened by their patients.[17] Accordingly, a breach of that duty that causes a death constitutes the actus reus for homicide. Similarly, a breach of the duty that causes serious bodily harm would be sufficient actus reus for an aggravated assault charge.

Proof of actus reus is not enough for conviction, of course. A criminal mens rea must also be proven.[18] And because criminal punishment is based on an assessment of moral blameworthiness, the mens rea must usually be at least gross negligence or recklessness, not the simple negligence used in the tort system to determine who pays whom.[19] At the same time, evil intent is not required for criminal

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12. WAYNE R. LAFAVE, CRIMINAL LAW 311 (4th ed. 2003). For exceptions, *see infra* text accompanying notes 13–16.

13. *Id.* at 310–11. *See also,* MODEL PENAL CODE § 2.01(3)(b) (1962) ("Liability for the commission of an offense may not be based on an omission unaccompanied by action unless: . . . a duty to perform the omitted act is otherwise imposed by law.").

14. LAFAVE, *supra* note 12, at 312–16. *See also,* People v. Beardsley, 113 N.W. 1128, 1129 (Mich. 1907).

15. *See, e.g.*, State v. Williams, 484 P.2d 1167 (Wash. 1971).

16. LAFAVE, *supra* note 12, at 797–98 (citing cases and stating that "[m]anslaughter liability has not infrequently been based upon criminal negligence or recklessness in omitting to act.").

17. Tarasoff v. Regents of the University of California, 551 P.2d.334, 340 (Cal. 1976).

18. PAUL ROBINSON, CRIMINAL LAW: CASE STUDIES AND CONTROVERSIES 146 (1st ed. 2005) ("The requirement of culpability distinguishes criminal law from other bodies of law.").

19. LAFAVE, *supra* note 12, at 264–67.

liability. To be guilty of manslaughter, for instance, one need not intend death to occur. An awareness that one's act, or failure to act, carries a substantial risk of death will suffice, and in some jurisdictions, the prosecution need only show that the defendant *should* have known that the failure created a significant potential for death.[20] Furthermore, a risk might be considered "substantial" even if it is below 50%.[21]

Now imagine Dr. Careful, a psychiatrist whose patient, Sam, has just confided in her that he plans to kill his girlfriend. Under the modern version of *Tarasoff* liability, once that threat occurs, Dr. Careful presumptively has a duty to take steps reasonably calculated to prevent the threat from being carried out. Those steps might include committing or in some other way aggressively treating Sam, calling the police or warning the girlfriend.[22] If Dr. Careful does not take one of these steps, and Sam kills his girlfriend, the doctor may be liable in tort.

The important point for present purposes, however, is that Dr. Careful may also be liable under criminal law for the crime of manslaughter. A breach of her *Tarasoff* duty would establish the criminal actus reus. And if she knew or should have known that failing to act created a substantial risk of the girlfriend's death—both of which are likely if a serious threat is made—a manslaughter conviction would be appropriate. In the alternative, Dr. Careful might be criminally liable for Sam's homicide on a complicity theory of liability. Under the Model Penal Code, a person is an accomplice to manslaughter if he or she purposely fails to perform a duty (which is true of Dr. Careful if she does not take the *Tarasoff* steps) and is aware of a substantial risk that the failure to perform this duty will lead to death of another.[23] Under the Code, this complicity liability for Sam's act would exist even if Sam is eventually found not guilty (because, for instance, he was insane at the time he

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20. *Id.* at 794–95; MODEL PENAL CODE §§ 2.02(2)(c) & (d) (1962) (stating that recklessness exists when a person "consciously disregards a substantial and unjustifiable risk" and negligence exists when a person "should be aware" of such a risk).

21. *See also*, People v. Hall, 999 P.2d 207, 217 (Colo. 2000) (quoting *People v. Deskins*, 927 P.2d 368, 373 (Colo. 1996), which held that "[a] risk does not have to be 'more likely than not to occur' or 'probable' in order to be substantial . . . Some risks may be substantial even if they carry a low degree of probability because the magnitude of the harm is potentially great").

22. *See Tarasoff*, 551 P.2d at 340 (listing options).

23. The Model Penal Code states that complicity exists when the person (1) has the "purpose of . . . facilitating . . . the offense"; (2) has a legal duty to prevent the commission of the offense and fails to make proper effort to do so; and (3) with respect to result crimes like homicide, has the mens rea for the relevant result (e.g., recklessness, if the charge is manslaughter). MODEL PENAL CODE §§ 2.06(3) & (4) (1962). Although criterion (1) would seem to foreclose complicity liability for clinicians in a *Tarasoff* scenario, the Code's commentary makes clear that it merely requires the accomplice to intend the omission, not the ultimate result caused by the principal, the mens rea for which is established by the relevant crime pursuant to criterion (3). *Id.*

killed his girlfriend).[24]

Of course, Dr. Careful may have one or more defenses to these charges, similar to those that could be raised in a tort case. First, she might argue that she could not take appropriate preventive steps because, for instance, there was insufficient time to do so, or because doing so would have put her in danger. Second, consistent with the *Tarasoff* duty in many jurisdictions,[25] criminal liability might not exist if the girlfriend already knew of Sam's violent hostility toward her, thus arguably obviating the need to protect her.[26]

A more likely argument on Dr. Careful's behalf would be that she lacked the relevant mens rea; to wit, she could contend that, despite Sam's threat, she did not think the girlfriend was in sufficient danger to require any special action on her part. Perhaps Sam had made such threats before and they amounted to nothing, or perhaps he made this one in a blustery or half-hearted manner that signaled a lack of motivation to carry through with the act. In many jurisdictions, she would only have to show she honestly believed these facts (i.e., that she was non-reckless); in others she would also have to show that the beliefs were reasonable (i.e., that she was not criminally negligent).[27]

Less credibly, Dr. Careful might argue that ignoring the risk that Sam presented was justifiable.[28] Specifically, she might contend that even if Sam represented a substantial risk to his girlfriend, she believed that the usual methods of managing that risk carried an even greater probability of substantial harm. For instance, Dr. Careful might assert that, while she believed there was a 30% chance that Sam would kill if no preventive steps were taken, she foresaw an 60% chance that the loss of liberty, stigma and coerced treatment associated with commitment would only worsen Sam's condition, and a 50% chance that exposing his threats to police or his girlfriend would make him more homicidal because he would be unwilling to seek help from therapists again.[29]

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24. MODEL PENAL CODE § 2.06(7) (1962).

25. *See* Ginsburg, *supra* note 5, at 19–25, 30–32.

26. *See* LAFAVE, *supra* note 12, at 799 (the victim's conduct "is a factor to be considered in determining whether the defendant's conduct, under all the circumstances, amounted to criminal negligence.").

27. *See* ROBINSON, *supra* note 18, at 639.

28. The Model Penal Code explicitly makes this part of the inquiry into recklessness and negligence. *See supra* note 20.

29. The government might argue, in response, that Dr. Careful should have realized that *non*-disclosure might also lead to commitment and loss of confidentiality if Sam hurt his girlfriend and prosecution ensued. Seldom recognized by those who oppose *Tarasoff* out of concern about confidentiality is that, if the threatened harm does occur, the revelation of private information is likely to be much more extensive than would occur through a simple warning disclosing only those facts necessary to prevent the harm.

If she is unsuccessful with these defenses, a final contention would be that her breach of the duty was not the proximate cause of the girlfriend's death. Sam clearly *is* a so-called "intervening" cause. [30] Yet *Tarasoff* rejected this lack-of-causation argument as a matter of tort law.[31] And although criminal law's causation requirements are theoretically more stringent,[32] if Sam's act was easily foreseeable in the absence of preventive action, then Dr. Careful's breach of the *Tarasoff* duty will probably be sufficient cause for punishment purposes as well. Recall that parents have been found criminally liable for harm caused by their children and employers for harm caused by their employees despite similarly attenuated causation.[33]

As this discussion illustrates, criminal liability, like civil liability, rests largely on an evaluation of mental health professionals' assessments of risk. A number of the articles in this symposium discuss this issue from an empirical perspective.[34] Here, it will be examined only from the perspective of the criminal law, which has other interesting implications for *Tarasoff*.

II. THE CRIMINAL LAW AND DANGEROUSNESS

Criminal punishment is generally imposed for a past harm, like homicide, rape, theft or fraud. But it is also routinely imposed on "dangerous" people who caused no harm. For instance, the inchoate crimes of attempt and conspiracy do not require a completed act, nor do crimes such as reckless endangerment.[35]

The criminal law does not use actuarial tables or clinical risk factors to determine whether persons charged with these crimes would have

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30. *See* Weathers v. Pilkinton, 754 S.W.2d 75, 78–79 (Tenn. 1988) (holding that a suicide by patient is an intervening event absolving a negligent therapist from liability unless the patient "did not know the nature or consequences of his act").

31. Actually, *Tarasoff* did not address the causation issue directly, but its holding that therapists could be liable for the acts of their patients indicates that the intervening cause defense is not available. *See* Winger v. Franciscan Med. Ctr., 701 N.E.2d 813, 819 (Ill. App. Ct. 1998) (holding, contrary to *Weathers*, that a therapist can be liable for the acts of a patient even when the patient is not "bereft of reason" at the time of the act).

32. *See, e.g.*, Commonwealth. v. Rementer, 598 A.2d 1300, 1306 (Pa. 1991) (quoting Commonwealth v. Howard, 402 A.2d 674, 676 (Pa. 1979)) ("Our cases emphasize that a criminal conviction requires 'a more direct causal connection' than tort concepts. . . . Thus not only do we demand that the defendant's conduct actually cause the victim's death . . . we also question . . . whether the fatal result was so extraordinary, remote or attenuated that it would be unfair to hold the defendant criminally responsible for it.").

33. *See supra* note 16 and accompanying text.

34. *See, e.g.*, *infra* note 45.

35. *See* MODEL PENAL CODE § 5.01 (attempt), § 5.03 (conspiracy), § 211.2 (reckless endangerment) (1962).

carried them out. Rather it relies on a number of common sense mechanisms. In defining the mens rea for these types of crimes, criminal law doctrine usually requires proof of an intent to cause the harm or at least knowledge on the part of the actor that he or she has done everything that needs to be done to cause the harm (which fails to occur only because of the victim's luck, police competence, or some other unforeseen event).[36] In defining the actus reus for inchoate crimes, criminal law usually requires a substantial step toward commission of a completed harm. For instance, conspiracy requires an agreement between two people to commit the crime, and in many jurisdictions it also requires proof of an overt act in furtherance of the conspiracy.[37] An attempt occurs only when the individual engages in conduct beyond "mere preparation" that evidences dangerous proximity to commission of a crime.[38] Reckless endangerment requires engaging in conduct that places or may place another person in imminent danger of death or serious bodily injury.[39]

Note that modern *Tarasoff* doctrine contemplates only the first of these two elements. While a patient's expression of an intent to cause harm is necessary to trigger *Tarasoff* analysis, it is also sufficient. Inchoate crimes normally require, in addition, some sort of overt act or conduct. Thus, Sam could not be prosecuted merely for his threat.[40] To convict him of attempt, there would also have to be proof that he took a substantial step toward carrying the threat out, such as buying a gun, setting up an appointment with the girlfriend, or developing a plan for the killing. A conviction for reckless endangerment would require that the harm be even more imminent.[41]

Perhaps *Tarasoff* analysis should take into account the criminal law's approach to dangerousness assessments. If it did, a therapist would be liable only if he or she both witnessed a direct threat *and* became aware

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36. *See* LAFAVE, *supra* note 12, at 628–31 (describing mens rea for conspiracy, which usually requires intent to achieve the objective); *see id.* at 583–87 (describing mens rea for attempt, which usually requires intent to complete the crime, but might only require intent to engage in conduct which one is aware or should be aware will cause harm).

37. *Id.* at 622–28 (describing actus reus for conspiracy).

38. *Id.* at 588–96 (describing actus reus for attempt).

39. MODEL PENAL CODE § 211.2 (1962).

40. Certain types of threats, not applicable here, may be a crime. *See, e.g.*, MODEL PENAL CODE § 211.3 (1962) (criminalizing threats meant to "terrorize another or to cause evacuation of a building"); 18 U.S.C. § 115(a) (2006) (threatening to assault an immediate family member of a U.S. official).

41. *See, e.g.*, MODEL PENAL CODE § 211.2 (1962) (stating that "[r]ecklessness and danger shall be presumed where a person knowingly points a firearm at or in the direction of another"); State v. Honeycutt, 54 S.W.3d 762, 771 (Tenn. 2001) (quoting TENN. CODE ANN. § 39-13-103(a) (2000) requiring that "death" or "serious bodily injury" be "imminent" to sustain a conviction for reckless endangerment).

of a substantial step toward carrying it out. That second requirement could prove crucial, since a jury that knows that a person has been killed or suffered serious injury will probably find incredible, however true it might be, the assertion that a patient's threat to harm that person did not represent a substantial risk.[42] The converse of this point is that criminal liability for a breach of the *Tarasoff* duty as it is *presently* defined is, in theory at least, highly likely.

III. IMPLICATIONS OF CRIMINAL LAW DOCTRINE FOR *TARASOFF*

These observations about the criminal liability created by recognition of a *Tarasoff* duty, if accepted, could trigger at least three possible reactions. The first is the conclusion that we should get rid of *Tarasoff*. If that doctrine can be used as a springboard for putting mental health professionals in prison, then, some might reason, it should be jettisoned.

Others might be willing to contemplate criminal liability for failing to prevent harm under tightly limited circumstances that evidence clear blameworthiness on the part of the clinician. Thus, a second reaction to the above discussion might be an attempt to limit *Tarasoff* in a manner that conforms to criminal law principles. Specifically, civil liability, and therefore criminal liability, might require that the mental health professional not only hear the patient issue a serious threat against a specified victim but also that the clinician observe, or in some other way find out, that the patient has taken a substantial step toward carrying it out.

A third reaction to the foregoing observations, which focuses on the manner of fulfilling the *Tarasoff* duty rather than on when it is triggered, is more complicated. It begins with an analysis of why mental health professionals have been saddled with a duty to prevent violent harm while other groups—including medical doctors, lawyers, teachers and ordinary citizens—have not. According to *Tarasoff*, the duty it announced exists because mental health professionals have a "special relationship" not only with their patients but also with the third parties their patients might harm.[43] The latter relationship apparently stems from clinicians' knowledge of their patients' violent propensities and the

42. In practice, even in those jurisdictions that require proof of recklessness (which contemplates a subjective awareness of the risk) criminal liability for violent acts the therapist did not take steps to prevent is likely to depend, as it does with civil liability, on whether the mental health professional *should* have foreseen those acts. *See* LAFAVE, *supra* note 12, at 269 ("Whether or not the defendant was consciously aware of the risk or simply failed to be aware is often a close question.").

43. Tarasoff v. Regents of the University of California, 551 P.2d.334, 343–44 (Cal. 1976). (finding a special relationship between doctor and patient); *see id.* at 349 (refusing to find such a relationship between police and patient).

clinicians' ability to do something about them. In other words, the California Supreme Court's assumption in *Tarasoff* seemed to be that, because clinicians get to know their patients and are trained in prognostication and treatment, they can justly be required to prevent those patients from harming others.[44]

That assumption does usefully distinguish mental health professionals from others to the extent the *Tarasoff* duty depends upon an ability to predict dangerousness and an ability to treat it. Although mental health professionals are not particularly good at foreseeing violence, those trained in modern risk assessment techniques are undoubtedly better than any other group at that task.[45] And, compared to laypeople, psychiatrists and psychologists are clearly superior at treating aggressive individuals,[46] and better equipped, both professionally and legally, to initiate civil commitment proceedings when appropriate.[47]

If, however, the *Tarasoff* duty is triggered solely by a serious threat of physical violence toward an identifiable victim, which is the law today in most jurisdictions that follow *Tarasoff*,[48] and if discharge of the duty can include a warning to the victim or the police, again something contemplated by current law, then the distinction between mental health professionals and others begins to disappear. Neither by training nor skill are mental health professionals necessarily more adept than anyone else at discerning when a specific threat has been made, especially if, as suggested above, a threat is defined as "serious" only if a significant step toward carrying it out occurs. Indeed, we routinely assume that ordinary citizens sitting on juries in attempt cases can make such determinations; even in *Tarasoff* suits, courts have held that juries do not need the help

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44. *Id.* at 345–46.

45. Some research suggests that mental health professionals who use clinical prediction techniques are no better than laypeople at assessing risk. Douglas Mossman, *Assessing Predictions of Violence: Being Accurate about Accuracy*, 62 J. CONSULTING & CLINICAL PSYCHIATRY 783, 790 (1994). However, laypeople cannot replicate the accuracy of mental health professionals trained to use actuarial devices or instruments such as the Violence Risk Appraisal Guide, Iterative Classification Trees, or the HCR-20. *See generally* Monahan, Tarasoff *at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497 (2006).

46. *See generally* CLINICAL TREATMENT OF THE VIOLENT PERSON (Loren Roth ed., 1987).

47. Although many states permit individuals other than mental health professionals to initiate a commitment proceeding or an emergency detention, virtually all also require that the petition be supported by clinical opinion on issues such as the existence of mental disorder and dangerousness. *See, e.g.*, CAL. CODE §§ 5150.05, 5150.3; N.Y. MENTAL HYG. LAW §§ 9.37, 9.39 (McKinney 2006); FLA. STAT. § 394.463(2)(a) (2006). The fact that detention of a person who is not "insane" can result in a false imprisonment or assault and battery action provides further incentive to involve mental health professionals in the decision as soon as possible. D.A. Cox, Annotation *Right, Without Judicial Proceeding, to Arrest and Detain One Who is, or is Suspected of Being, Mentally Deranged*, 92 A.L.R.2d 570 § 2 (1963).

48. *See supra* note 4.

of experts to determine whether violation of the duty to act after a threat has occurred.[49] And it is obvious that laypeople are just as able as clinicians at alerting the police or the potential victim when such a threat occurs. To the extent that *Tarasoff* requires mental health professionals to provide warnings when they hear a serious threat aimed at an identifiable victim, it logically should require laypeople to do so as well. The argument for such a duty may even be stronger with respect to some groups such as teachers and ordinary citizens, given that they are not restricted by confidentiality rules from making disclosures.

Far from countering this conclusion, the precedent that *Tarasoff* cited in support of its decision imposing a special duty on mental health professionals actually bolsters the argument that these individuals are not distinguishable from others when the issue is whether police or potential victims should be alerted about a serious threat. The California Supreme Court relied on two lines of cases in justifying its holding that mental health professionals have a special relationship with their patients' potential victims. First, it pointed to decisions in which a treating facility was found liable for negligent release of a patient.[50] Second, it cited cases where doctors were found liable for failing to warn a patient's family that he or she suffered from a contagious disease.[51] In both of these situations, clinicians are acting on their special knowledge and authority. Releasing someone from a treatment program prematurely or without proper aftercare precautions is a bad *treatment* decision, and one which only the treating entity has sufficient information and proper authority to make. And doctors alone have the expertise and access necessary to ascertain whether someone is contagious, a condition which only a doctor can treat or protect against through quarantine, actual or constructive (through giving potential victims a warning). In contrast, anyone, doctor or layperson, who hears one person issue a serious threat toward another has the ability to

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49. In *Ewing v. Northridge Hosp. Med. Ctr.*, 16 Cal.Rptr.3d 591, 601–02 (Cal. Ct. App. 2004), the court held:

> By enacting section 43.92 [the *Tarasoff* statute], the Legislature intended to limit a psychotherapist's liability for failure to warn to instances in which the therapist actually believed or predicted that the patient posed a serious threat of inflicting grave bodily injury. The mind-set of a therapist can be evaluated by resort to common knowledge without the aid of expert testimony. . . . 'Liability is not based on a breach of the standard of care but rather the specific duty to warn which arises from communication of a threat.'

Id.

50. *See* Tarasoff v. Regents of the University of California, 551 P.2d.334, 344 (Cal. 1976). (citing Merchants Nat. Bank & Trust Co. of Fargo v. United States, 272 F.Supp. 409 (D.N.D. 1967), which found a hospital liable for failing to tell an aftercare volunteer about a patient's violent propensities).

51. *Id.* at 344.

understand it and alert the appropriate parties. Again, laypeople are in the same position as clinicians to the extent the *Tarasoff* duty is framed as an obligation to warn when a serious threat to an identifiable victim is issued.

If that is so, then given the close relationship between civil and criminal law noted earlier, *laypeople*, not just clinicians, can be liable *criminally*, not just civilly, when they fail to warn of a specific serious threat. Yet that outcome, most agree, would take things too far. Under the common law of crimes, misprision of a felony was a crime itself.[52] But even under the common law, this crime generally applied only to failure to report a completed felony; as one commentator who recently examined the relevant cases put it,

> with one exception, in all cases in which the facts are described, the prosecution for misprision of a felony has never proceeded against a defendant for his or her failure to stop a felony or arrest a felon; and contemporary American authorities acknowledge that the duty imposed by the offense is limited to disclosure of knowledge.[53]

Today most states do not even criminalize breach of the latter duty.[54]

This reluctance to impose a duty to prevent, and in most states even to report, crime is based on a number of considerations. A Florida court rejected adoption of the crime of misprision of felony in these words:

> While it may be desirable, even essential, that we encourage citizens to "get involved" to help reduce crime, they ought not be adjudicated criminals themselves if they don't. The fear of such a consequence is a fear from which our traditional concepts of peace and quietude guarantee freedom. We cherish the right to mind our own business when our own best interests dictate. Accordingly, we hold that misprision of felony has not been adopted into, and is not a part of, Florida substantive law.[55]

The federal code does recognize the crime of misprision, but only if the prosecution shows an affirmative act of concealment, as when the individual refuses to talk to, or lies to, the police about the underlying

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52. LAFAVE, *supra* note 12, at 713.

53. Gabriel D. M. Ciociola, *Misprision of Felony and Its Progeny*, 41 BRANDEIS L.J. 697, 700–01 (2003). Most jurisdictions also refuse to impose civil liability for a failure to prevent harm. *See also* RESTATEMENT (SECOND) OF TORTS § 314. Indeed, even a "doctor may flout his Hippocratic oath and deny aid to a stranger." JOHN G. FLEMING, THE LAW OF TORTS 144 (5th ed. 1977).

54. LAFAVE, *supra* note 12, at 713 (Misprision of felony is "no longer an offense in most jurisdictions"). Note that the absence of such a crime would not get clinicians in *Tarasoff* states off the hook, since they have an independent duty to protect.

55. Holland v. State, 302 So.2d 806, 810 (Fla. Ct. App. 1974). *See also*, William M. Landes & Richard A. Posner, *Salvors, Findors, Good Samaritans, and Other Rescuers: An Economic Study of Law and Altruism*, 7 J. LEGAL STUD. 83 (1978).

felony.[56] Finally, even in those jurisdictions that make failing to report a crime, such a failure is usually only a misdemeanor, not the serious crime it would be if based on a breach of *Tarasoff* and the ensuing crime.[57]

Warnings to the police or the victim should be a legally required option for mental health professionals only if we are willing to require non-clinicians to exercise the same options when they are confronted with specific threats. Since we apparently are not willing to do so, the end result of this reasoning is that *Tarasoff* should only impose a duty on mental health professionals to handle dangerous patients through avenues that are *not* easily available to laypeople: outpatient therapy or involuntary commitment.

In short, viewed through the prism of criminal law, *Tarasoff* should be recast as a duty to treat dangerousness, not prevent harm in any way possible. This duty to treat derives from the most obvious distinction between mental health professionals and others: their ability to deal with psychological and relational problems, and their authority, if they cannot deal with those problems, to commit patients involuntarily. The ability to treat comes from mental health professionals' training and experience. Ultimately, so does their authority to commit. Although in many jurisdictions "any person" can petition for commitment, in practice and in law the onus falls on mental health professionals to support the case for involuntary hospitalization.[58] Laypeople, if they have any role at all, have no real power in this setting.[59]

IV. THE IMPACT OF A DUTY TO TREAT

This reconceptualization of *Tarasoff* as a duty to treat has several consequences, all of which are probably advantages. As already noted, the proposed reconceptualization prevents expansion of *Tarasoff*

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56. 18 U.S.C. § 4 (2006). *See also* United States v. Farrar, 38 F.2d 515, 517 (D. Mass. 1930) ("Mere silence after knowledge of the commission of the crime is not sufficient.").

57. At common law, misprision of felony was a misdemeanor, although under federal law it can be a felony. Ciociola, *supra* note 53, at 722 n.150. States that have retained misprision and modern failure-to-report statutes make the crime a misdemeanor. *Id.* at 726–28, 731–33.

58. *See supra* note 47.

59. One commentator has argued that criminal defense attorneys have a *Tarasoff* duty to seek commitment for clients who evidence dangerousness because, compared to the typical citizen, they have greater knowledge of criminal behavior and greater professional stature, both of which enhance the likelihood their allegations will provide probable cause to believe that detention in a mental hospital is necessary. Michael A. Backstrom, *Unveiling the Truth When It Matters Most: Implementing the* Tarasoff *Duty for California's Lawyers*, 73 S. CAL. L. REV. 139, 163–65 (1999). But, as the author admits, "lawyers cannot independently order commitment," and no receiving facility is likely to detain an individual simply because a lawyer asserts that it should. *Id.* at 164.

liability outside of the mental health professions. Second, it simplifies the clinician's decision-making in specific threat situations by narrowing the options to outpatient treatment or inpatient treatment, options which are also probably the most effective (since, as many have pointed out, alerting the police or the victim simply passes the buck to them).[60] Third, if confidentiality is breached it will be breached only in a civil commitment hearing, which usually will mean less exposure of private information to the outside world than occurs under a warnings regime. Fourth, hard decisions can be turned over to a judge, whose ruling will immunize the clinician from liability.

This last consequence may strike some as a disadvantage because it could create a temptation to treat every threat as grounds for a commitment petition. Indeed, in the law review article that allegedly spurred the *Tarasoff* decision,[61] Fleming and Maximov strongly implied that a duty to warn is necessary to prevent overuse of civil commitment,[62] which they believed to be "constitutionally suspect" because of its "drastic" psychological and practical consequences and its similarity to punishment.[63] But much has changed in the past thirty years. Commitment no longer consists of long-term incarceration in ill-kept warehouses masquerading as hospitals.[64] The average duration of involuntary hospitalization for those who are dangerous to others is probably well under a month, usually followed by outpatient treatment.[65] A warning is still less of a restriction on liberty than commitment but is substantially less so than it was three decades ago.

More importantly, Fleming and Maximov's suggestion that warning the threatened victim could somehow supercede commitment as the primary means of handling a mentally ill and dangerous patient never made much sense. If a patient is considered dangerous, most clinicians

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60. *See, e.g.*, Stone, *supra* note 2, at 374. This formulation also is more closely aligned to the precedent, on which *Tarasoff* relied, holding hospitals liable for premature release of dangerous patients. *See* Tarasoff v. Regents of the University of California, 551 P.2d. 334, 343 (Cal. 1976).

61. *See* Stone, *supra* note 2, at 361.

62. John G. Fleming & Bruce Maximov, Note, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1065–66 (1974) (listing the therapist's options and concluding that "action more drastic than necessary to afford reasonable protection for the third party subjects the patient to unwarranted invasion of his rights").

63. *Id.* at 1051–55.

64. Paul F. Stavis, *Foreword: First Annual Forum on Mental Illness and the Law*, 11 GEO. MASON U. CIV. RTS. L.J. 1, 12 (2000) ("With few exceptions, the large and long-term psychiatric hospital has gone the way of the dinosaur.").

65. RALPH REISNER ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 814 (2004) (reporting statistics of average hospital stays for *all* patients, including those who are chronically unable to care for themselves and not easily treatable in the community, between 41 and 90 days).

will opt for commitment over a warning.[66] And, even if they do choose the latter option, it is unlikely to function either as an effective alternative to commitment or as a less restrictive one. Potential victims who are told they are a target will either do nothing, out of fear, fatalism or disbelief, or they will demand that the therapist or police take some action, which in most cases will be the commitment that Fleming and Maximov wanted to avoid.

The one situation in which options other than commitment are useful, a situation that is admittedly likely to be fairly common, is when the patient is dangerous but not mentally disordered, and thus not committable. Again, however, unless we want to make laypeople liable for failure to alert the police or to warn the potential victim in such situations, we should also avoid imposing that duty on mental health professionals. At the same time, the rule proposed above would still impose on the mental health professional a duty to treat a non-committable dangerous patient to try to prevent the harm. That treatment might include "talking the patient down,"[67] reminding the patient of the consequences of crime (and perhaps also mentioning that the therapist may have to reveal threats and other indicia of homicidal motivation in any subsequent prosecution[68]), or having the patient meet with the threatened victim to work out problems.[69] If these types of steps are not taken, liability, both civil and criminal, might still attach.

Furthermore, clinicians could still be permitted to disclose information necessary to prevent harm under limited circumstances. For instance, Florida law provides that, "[w]hen a patient has declared an intention to harm other persons," the clinician *may* release "sufficient information to provide adequate warning to the person threatened with harm by the patient."[70] The ethical rules governing lawyers endorse the same concept. According to the Model Rules of Professional Conduct,

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66. Buckner & Firestone, *supra* note 10, at 220 (after summarizing the relevant empirical data, concluding that "the mechanisms recommended in protective statutes–warning the victim and police–are rarely utilized in favor of hospitalization.").

67. Robert Schopp & David Wexler, *Shooting Yourself in the Foot with Due Care: Psychotherapists and Crystallized Standards of Tort Liability*, 17 J. PSYCHIATRY & L. 163, 177 (1989) (describing case in which the therapist "believes from past experience with [the patient] that she can best serve his interests and those of the public by maintaining therapeutic contact, calming him down, and talking him into leaving the weapon at home . . .").

68. *Cf.* United States v. Hayes, 227 F.3d 578, 579 (6th Cir. 2000) (rejecting a "dangerous patient" exception to the psychotherapist patient privilege), *with* Guerrier v. State, 811 So.2d 852, 856 (Fl. Ct. App. 2002) (adopting the exception).

69. *See* Damon Muir Walcott et al., *Current Analysis of the* Tarasoff *Duty: An Evolution Towards the Limitation of the Duty to Protect*, 19 BEHAV. SCI. & L. 325, 340 (2001) (suggesting this approach).

70. FL. STAT. § 394.4615(3)(a) (2006).

"a lawyer may reveal information relating to the representation of a client to the extent the lawyer reasonably believes necessary . . . to prevent reasonably certain death or substantial bodily harm."[71] The important difference between these provisions and *Tarasoff* is that the former make disclosure discretionary, rather than mandatory. Under this regime, clinicians and lawyers who believe that admonitions about potential *Tarasoff* actions are off-putting would also have more flexibility as to whether and how to provide that information under informed consent rules.[72]

CONCLUSION

This examination of *Tarasoff* through the prism of criminal law can be reduced to a few simple points. *Tarasoff* liability might mean criminal liability as well, perhaps even for manslaughter in cases in which the patient kills someone. If we want to mitigate that effect, we might take a cue from the criminal law's treatment of dangerousness as a basis for punishment, and require that the therapist be aware not only of a threat aimed a specific victim—the typical modern *Tarasoff* formulation—but also of conduct aimed at carrying out that threat that cannot justifiably be ignored. To avoid the possibility that *Tarasoff* will be interpreted to impose civil or criminal liability on laypeople, we might also eliminate the clinician's duty to take any preventive steps other than those aimed at doing what only clinicians are expert at doing—treating dangerousness. So limited, *Tarasoff* would require clinicians to breach confidentiality only when a dangerous patient is committable and not otherwise treatable.

In one of the papers for this symposium, Professors Buel and Drew argue that lawyers should have a tort duty to warn about harm threatened by their clients (at least in domestic violence situations) and thus, by implication, that mental health professionals should have an analogous duty.[73] Indeed, Buel and Drew's view is that a warning is such simple step, and can be so effective at preventing significant harm, that

71. MODEL RULES OF PROF'L CONDUCT R. 1.6(b)(1) (2003).

72. Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655, 660 (1991) ("Forensic psychologists inform their clients of the limitations to the confidentiality of their services and their products ... by providing them with an understandable statement of their rights, privileges, and the limitations of confidentiality."); MODEL RULES OF PROF'L CONDUCT R. 1.4(b) (2003) ("A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation.").

73. Sara Buel & Margaret Drew, *Do Ask and Do Tell: Rethinking the Lawyer's Duty to Warn in Domestic Abuse Cases*, 75 U. CIN. L. REV. 447 (2006).

concerns about confidentiality and agency can never trump this duty.[74] Nor are they satisfied with an ethical, as opposed to tort, remedy,[75] along the lines of those few states ethics codes that *require* disclosure of client communications if necessary to prevent death or serious bodily harm.[76] For reasons developed in this article, their logic also supports imposing a duty to warn on *anyone* confronted with a direct threat toward a battered individual, as well as on police, doctors and others who do not hear a direct threat but, like lawyers, can be charged with knowledge about the dynamics of domestic violence, a duty that could be backed up by criminal liability.

Maybe that should be the law; certainly when domestic harm occurs there is a strong urge to blame those who might have been able to prevent it. But, for reasons suggested by the original opponents of *Tarasoff* and summarized in the introduction to this article, reinstating the common law version of misprision of felony or its tort equivalent will not necessarily reduce overall harm, could significantly chill professional practices, and might damage relationships between the warners and their patients, clients or friends. I am ultimately undecided on the best course to take. Thirty years after *Tarasoff*, the jury is still out as to how to best prevent the public peril posed by threatening individuals.

74. *Id.*

75. *Id.*

76. *See, e.g.*, FL. RULES OF PROF'L CONDUCT R. 4-1.6(b) (2006).