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J. Thomas Sullivan

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MASS SHOOTINGS, MENTAL "ILLNESS," AND *TARASOFF*

J. Thomas Sullivan*

ABSTRACT

The continuing public attention focused on acts of mass violence, including mass shootings, has understandably created significant concerns over the ability to protect individuals from death and injury attributable to these acts. At least two generalized explanations for this kind of violence have been put forward, based on the nature of the acts and apparent motivation of the perpetrators, who are often killed in the process by themselves or law enforcement officers. Many acts of mass violence are committed by individuals confirmed to be terrorists, acting with political or religious-political motivations. Others are assumed to be committed by individuals acting out of mental instability. For at least the latter, evidence of prior mental health problems or treatment affords support for the notion that mental health professionals may offer the potential for prevention in some cases or instances. While looking to the mental health professions for solutions to some cases of mass violence may seem logical and has resulted in legislative responses that recognize or create a duty for mental health professionals to warn or take other protective

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action to prevent injury to third persons, it is far from clear that this approach can be counted on to yield favorable results, and certainly not with respect to all, or even a majority of episodes of mass violence.

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INTRODUCTION: THE LAS VEGAS MASSACRE, AND AFTER

The Las Vegas mass shooting committed by Stephen Paddock, who killed himself after fatally wounding fifty-eight outdoor concert-goers and injuring approximately 500 more during a relatively short but extremely intense shooting spree using numerous assault rifles,[1] now ranks as the single most violent mass shooting episode in United States history.[2] Paddock unleashed his assault on October 1, 2017, firing from a room at the Mandalay Bay Resort and Casino into a crowd attending a music concert on the street below. In the aftermath of the dramatic assault, questions about the shooter's motivation remain unanswered.[3] Apparently, however, there has been no evidence of neurocognitive disorders or mental illness uncovered, reflecting a common question posed in the wake of such events as to what would cause an individual to engage in this kind of horrible act.

President Donald Trump offered his view of Paddock's motivation to reporters at a Cabinet meeting:

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[1] *Las Vegas Shooting: What We Know*, CNN (Oct. 3, 2017), https://www.cnn.com/2017/10/02/us/las-vegas-shooting-what-we-know. The number of dead and injured victims fluctuated with early news reports, but an *Associated Press* story published on October 5 and quoted in the *USA Today* article reported: "Clark County Coroner John Fudenberg said all 58 victims in the shooting at a Las Vegas concert have been identified and families notified. Fudenberg declined to answer questions about how the victims died." *Coroner Says All Vegas Victims Now Identified*, USA TODAY (Oct. 5, 2017, 5:43 PM), https://www.usatoday.com/videos/news/nation/2017/10/06/coroner-says-all-vegas-victims-now-identified/106342976/.

[2] Leila Fadel, *'You Can Get Through It': Las Vegas Shooting Survivors Rebuild Their Lives*, NPR (Sept. 23, 2018, 7:53 AM), https://www.npr.org/2018/09/23/649264345/one-year-after-the-las-vegas-shooting-2-survivors-remember. The Las Vegas shooting is only one of several *most* lethal attacks in U.S. history, with the deadliest assault being the terrorist attack on World Trade Center Towers on September 11, 2001. Pamela Engel & Ellen Ioanes, *What Happened on 9/11, 19 Years Ago*, BUS. INSIDER (Sept. 10, 2020, 3:39 PM), https://www.businessinsider.com/what-happened-on-911-why-2016-9.

[3] *See, e.g.*, Melissa Healy, *What Drove Las Vegas Shooter to Kill? We Don't Know, and It Drives Us Crazy*, L.A. TIMES (Oct. 12, 2017), http://www.latimes.com/science/sciencenow/la-sci-sn-shooting-mental-health-20171012-story.html ("Police detectives and criminal profilers are working overtime in their efforts to dissect Paddock's behavior, circumstances and psychological state in the lead-up to the shootings. Mental health professionals and experts on human behavior, meanwhile, are bearing witness to a more common and less mysterious response on the part of Americans: a sense that without an explanation for Paddock's actions, we cannot psychologically close the chapter on this shooting.").

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> I guess a lot of people think they understand what happened, but he was a demented, sick individual. . . .The wires were crossed pretty badly in his brain. Extremely badly in his brain. And it's a very sad event.[4]

I. IDENTIFYING THE PROBLEM: MASS SHOOTINGS AND THE SHOOTER'S STATE OF MIND

The sheer magnitude of the massacre committed by deceased suspect Stephen Paddock, apparently acting solo or without accomplice assistance, necessarily raised the question of why any individual would commit such a crime. What motivation could explain such a random act of mass violence?[5] President Trump's characterization of Paddock as "a demented, sick individual" hardly seems unreasonable in light of the circumstances of the Las Vegas mass shooting.

Within a few months, other mass shootings had occurred, including one at a church in Sutherland Springs, Texas, on November 5, 2017.[6] There, shooter Devin Patrick Kelley, dressed in tactical/military gear, shot forty-six people with an "assault-style" rifle, killing twenty-six churchgoers while they were attending Sunday morning services at the First Baptist Church. He had "escaped" from an inpatient facility in 2012 and had a history of domestic violence, suicidal behavior, and cruelty to animals.[7]

Then, on February 14, 2018, seventeen students were killed and seventeen others were wounded during the shooting at Marjory Stoneman Douglas High School in Parkland, Florida. The mass murder was committed by Nicholas Cruz, a former student at the school armed with an assault rifle. Cruz had a long history of school and social service interventions due to behavior that was "moody, impulsive, angry,

[4] Dana Dovey, *Trump Says Las Vegas Shooter's Brain Was Wired up Extremely Badly: Autopsy Literally Just Showed This Wasn't True*, NEWSWEEK (Oct. 10, 2017, 4:36 PM), http://www.newsweek.com/trump-says-las-vegas-shooters-brain-was-wired-extremely-badly-autopsy-686312.

[5] Healy, *supra* note 3.

[6] David Fernandez, Christopher Mele & Manny Fernandez, *Gunman Kills at Least 26 in Attack on Rural Texas Church*, N.Y. TIMES (Nov. 5, 2017), https://www.nytimes.com/2017/11/05/us/church-shooting-texas.html.

[7] *See* Eli Rosenberg, Derek Hawkins & Julie Tate, *Who Is Devin Patrick Kelley, the Gunman Officials Say Killed Churchgoers in Sutherland Springs, Tex.?*, WASH. POST (Nov. 6, 2017), https://www.washingtonpost.com/news/morning-mix/wp/2017/11/06/who-is-devin-patrick-kelley-gunman-who-officials-say-killed-churchgoers-in-sutherland-springs/.

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attention seeking, annoy[ing] others on purpose and threaten[ing] to hurt others."[8] In the aftermath of this shooting, which garnered national attention based on the students' demonstrations supporting gun regulation, President Trump commented on the need to provide additional security in schools and to "tackle the difficult issue of mental health."[9]

The Florida high school shooting continued the pattern of mass shootings dominating the news in the United States in recent years,[10] all generating renewed public debate over the availability of firearms, specifically assault rifles, and the mental stability of the individuals perpetrating the violence. President Trump focused on the mental health of the offenders perhaps to deflect attention from the gun control debate and to avoid possible legislation. However, he also relied on a common perception that perpetrators of these mass murders must be mentally compromised—that rational individuals could not be responsible for these episodes of violence.

In the aftermath of the Parkland, Florida high school shooting, the *New York Times* related President Trump's responses to other recent mass shootings and his focus on mental impairment as the cause of these acts:

> "So many signs that the Florida shooter was mentally disturbed, even expelled from school for bad and erratic behavior," Mr. Trump said in a tweet hours before he addressed the public. "Neighbors and classmates knew he was a big problem. Must always report such instances to authorities, again and again!"
>
> He delivered similar remarks in November, after a gunman with a military-style rifle mowed down more than two dozen parishioners in a church in Sutherland Springs, Tex. Mr. Trump told reporters that the problem "isn't a guns situation" and that the shooting signified "a mental health problem at the highest level."

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[8] Rafael Olmeda, *School Officials Worried About Nikolas Cruz and Guns 18 Months Before Mass Shooting*, S. FLA. SUN SENTINEL (Mar. 16, 2018), https://www.sun-sentinel.com/local/broward/parkland/florida-school-shooting/fl-reg-florida-school-shooting-mental-health-20180316-story.html.

[9] Katie Rogers, *After Florida Shooting, Trump Focuses on Mental Health Over Guns*, N.Y. TIMES (Feb. 18, 2018), https://www.nytimes.com/2018/02/15/us/politics/trump-florida-shooting-guns.html.

[10] The *New York Times* reported on April 10, 2019, in a follow-up article on the Parkland shooting: "The F.B.I. identified 27 active-shooter incidents in the United States last year, according to a report the bureau published on Wednesday. The episodes, which spanned 16 states, killed 85 people. None was deadlier than the Parkland shooting." Patricia Mazzei, *Parkland Victims' Families Sue, Claiming Negligence in Mass Shooting*, N.Y. TIMES (Apr. 10, 2019), https://www.nytimes.com/2019/04/10/us/parkland-lawsuits-safety.html.

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> In October, after a gunman in Las Vegas killed 58 people and wounded hundreds in the deadliest mass shooting in United States history, Mr. Trump called the assailant "a very sick man" and a "demented person."[11]

The evidence that mental illness was responsible for the acts perpetrated by individuals who committed these mass shootings is not clear. But, over time, the motivations of individuals responsible for these episodes will become clearer in at least some cases. For instance, there is evidence developed in news reporting and in litigation arising from the Parkland shooting[12] that the perpetrator had a lengthy history of involvement with mental health providers and had been prescribed psychoactive medication.[13]

There is little evidence, however, that mental illness actually caused the individuals responsible for these mass shootings to engage in shootings or other acts of mass violence. Evidence shows that some perpetrators suffered from mental illness or emotional problems at some point prior to their homicidal rampages, but it is more difficult to establish a direct link that would permit the inference that intervention by mental health professionals would have prevented the mass shootings. Nevertheless, the suggestion has been continually advanced that the underlying problem reflected in these episodes is that mental health issues, rather than other explanations—such as ideological terrorism—should be the focus of the nation's response to these shootings. The response is itself unfocused, while the suggestions by President Trump and others of mental impairment as the cause for mass shootings implies that the mental health community can provide the solution.

The issue of the shooter's intent is complicated by evidence at least suggesting alternative theories that may reflect sociopathic personalities. For example, the shooting at a Jewish synagogue, The Tree of Life Congregation, in which eleven worshipers were killed and six injured, was perpetrated by Robert Gregory Bowers,

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[11] Rogers, *supra* note 9.

[12] Megan O'Matz, *Mental Health Provider Had Long History with Parkland Shooter: Was Agency Negligent?*, SOUTH FLA. SUN SENTINEL (Jan. 16, 2019), https://www.sun-sentinel.com/local/broward/parkland/florida-school-shooting/fl-ne-henderson-cruz-civil-suit-20190116-story.html. The author was the member of the Sun Sentinel reporting team that was awarded the Pulitzer Prize for coverage of the shooting. *Id.* Numerous civil actions have been filed against school officials, mental health providers and individuals, including the school's public safety officer who reportedly failed to respond appropriately to the shooting inside the school. *See* Mazzei, *supra* note 10.

[13] *See, e.g.*, Olmeda, *supra* note 8. *Sherman Douglass High School Shooting*, https://en.wikipedia.org/wiki/Stoneman_Douglas_High_School_shooting (last visited Sept. 30, 2019).

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whose social media posts indicate white supremacist, anti-Semitic, neo-Nazi beliefs.[14] Similarly, social media posts linked to Patrick Crusius, arrested after the fatal shooting of twenty-two people at a Walmart store in El Paso, Texas, on August 3, 2019, with at least twenty-four others known injured at the time, included the shooting suspect's white supremacist manifesto. His post discloses that the attack was a "response to the Hispanic invasion of Texas."[15]

The El Paso shooting followed on the heels of a shooting that killed four and injured thirteen, including the shooter, at the Gilroy Garlic Festival in Gilroy, California, on July 28, 2019. The Gilroy shooter, a nineteen-year-old white male, had no known history of mental illness and had posted a message on social media immediately before the shooting directing people to read *Might Is Right*, a book commonly used to "justify racism, slavery and colonialism."[16]

Following the El Paso attack and another mass shooting at the Ned Peppers Bar in Dayton, Ohio the following day in which ten people were killed, including the shooter, and twenty-seven others were wounded,[17] President Trump again blamed

[14] *See* Campbell Robertson, Christopher Mele & Sabrina Tavernise, *11 Killed in Synagogue Massacre; Suspect Charged with 29 Counts*, N.Y. TIMES (Oct. 27, 2018), https://www.nytimes.com/2018/10/27/us/active-shooter-pittsburgh-synagogue-shooting.html. The shooting occurred on October 27, 2018. *Id.*

[15] Nicholas Bogel-Burroughs, *'I'm the Shooter': El Paso Suspect Confessed to Targeting Mexicans, Police Say*, N.Y. TIMES (Aug. 9, 2019), https://www.nytimes.com/2019/08/09/us/el-paso-suspect-confession.html. He drove ten to eleven hours from Allen, Texas, to the store location in El Paso, on the Texas border with Mexico, and used a semi-automatic assault rifle in the attack. *Id.*

[16] Ruben Vives, Richard Winton, Hannah Fry, Matthew Ormseth, Laura J. Nelson, Colleen Shalby & Hailey Branson-Potts, *What We Know About the Gilroy Garlic Festival Shooting Suspect*, L.A. TIMES (July 29, 2019), https://www.latimes.com/california/story/2019-07-29/what-we-know-about-gilroy-garlic-festival-shooting-suspect-santino-william-legan.

[17] Madeline Mitchell, Kevin Grasha, Keith Biery Golick, Cameron Knight, Rachel Berry & Anne Saker, *Connor Betts: Dayton Gunman Played in 'Pornogrind' Metal Band, Had a 'Kill List,' Choked Women*, CIN. ENQUIRER (Aug. 4, 2019), https://www.cincinnati.com/story/news/2019/08/04/dayton-shooting-what-we-know-gunman/1916121001 (showing that the killer, Connor Betts, composed a "kill list" and "rape list" in high school, had a history of depression and domestic violence, and has an expunged juvenile record). He shot and killed his sister before shooting others at the bar, using an AR-15 style pistol to shoot his 36 victims in 32 seconds. Amber Hunt, *In Dayton, 32 Seconds That Changed Everything*, CIN. ENQUIRER (Aug. 8, 2019), https://www.cincinnati.com/story/news/2019/08/08/dayton-shooting-32-seconds-changed-everything/1935832001/.

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mental illness for the mass shootings. He explained, "This is also a mental illness problem. . . . These are people that are very, very seriously mentally ill."[18]

While President Trump's pronouncement of mental illness as the cause of mass shootings is not based on expert opinion, education, or training in mental health—his background is in real estate development—his characterization of the mental state of shooters in these events undoubtedly would be echoed by others. However, there is a danger in simplifying causation and attributing a common, though general, diagnostic explanation to individual behavior not individually examined. Incidents of mass violence, including mass shootings, logically raise questions about the mental state of the perpetrator, or perpetrators, or accomplices, particularly whether these acts could have been prevented by professional intervention.

The consistent theme in the aftermath of the recurring episodes of mass violence involving firearms in the United States over the past few years[19] has been the typically unanswered questions about the shooter's state of mind. Speculation has focused on symptoms of major mental illness and aberrant thinking or behavior exhibited by perpetrators prior to these episodes.[20] Evidence of prior treatment by

[18] Spencer Kimball, *Trump Says Mass Shootings in El Paso and Dayton Are a "Mental Illness Problem,"* CNBC (Aug. 4, 2019), https://www.cnbc.com/2019/08/04/trump-says-hate-has-no-place-in-our-country-after-shootings-in-dayton-and-el-paso.html.

[19] Speculation concerning the cause of a perceived increase in episodes of mass violence, particularly focusing on mass shootings, is not necessarily a *recent* concern at all, however. See, for example, Mark Follman, Gavin Aronsen & Deanna Pan, *A Guide to Mass Shootings in America*, MOTHER JONES (Feb. 26, 2020), http://www.motherjones.com/politics/2012/07/mass-shootings-map?page=2, for a history of mass shooting violence in the United States over the past thirty-five years published five years ago. *Mother Jones* is a liberal/populist publication. For another perspective, see Jesse Singal, *Mass Shootings Aren't on the Rise*, N.Y. MAG. (June 11, 2014), http://nymag.com/scienceofus/2014/06/mass-shootings-arent-on-the-rise.html, relating conclusions of nationally prominent Northeastern University criminologist James Fox. *Mother Jones* updated its history that now includes the incidence of mass shootings over the past five years. Mark Follman, Gavin Aronsen & Deanna Pan, *US Mass Shootings, 1982–2019: Data From Mother Jones' Investigation*, MOTHER JONES, https://www.motherjones.com/politics/2012/12/mass-shootings-mother-jones-full-data/; *see also* Mazzei, *supra* note 10 ("The F.B.I. identified 27 active-shooter incidents in the United States last year, according to a report the bureau published on Wednesday. The episodes, which spanned 16 states, killed 85 people. None was deadlier than the Parkland shooting.").

[20] *See, e.g.*, Dewey G. Cornell, *Gun Violence and Mass Shootings—Myths, Facts and Solutions*, WASH. POST (June 11, 2014), http://www.washingtonpost.com/news/the-watch/wp/2014/06/11/gun-violence-and-mass-shootings-myths-facts-and-solutions/. Dr. Cornell, a clinical psychologist and faculty associate at the Institute of Law, Psychiatry and Public Policy at the University of Virginia, writes in this guest editorial that mental illness is not a common factor in recent acts of mass violence, while noting that statistical evidence shows that incidents of mass violence are actually decreasing, not increasing over the past twenty years. *Id.* He explains:

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mental health professionals is offered to suggest that the tragic deaths of victims,[21] often children targeted in attacks committed at schools and other public forums, could have been prevented by appropriate intervention.[22] The gun lobby, resisting

> It seems intuitive that anyone who commits a mass shooting must be mentally ill, but this is a misuse of the term "mental illness." Mental illness is a term reserved for the most severe mental disorders where the person has severe symptoms such as delusions or hallucinations. Decades of mental health research show that only a small proportion of persons with mental illness commit violent acts, and together they account for only a fraction of violent crime. Some mass shooters have had a mental illness. Most do not.

Id. Dr. Cornell does explain, however, that mental health intervention is an important factor in preventing mass shootings:

> In case after case of mass shootings, we learn later that family members, friends, and even mental health professionals were concerned that someone needed help. Predicting violence is difficult, but identifying that someone needs assistance is not so difficult. This is where we need to readjust our focus and concentrate on helping people in distress. This approach requires not only a change in police policy but community mental health services that are oriented around prevention.

Id.

[21] *Time Magazine* published a list of the victims killed as a result of shootings in incidents of mass violence on *Facebook*, with the included explanation:

> To compile this list of 630 victims of mass shootings, we've relied on the database maintained by the magazine Mother Jones, one of the most authoritative records of such incidents. It tracks mass shootings in the United States beginning in 1982. There is no one authoritative source on how many people have died in mass shootings—or, in fact, what constitutes a mass shooting. Until recently, a mass shooting was traditionally defined as an attack that kills at least four people, excluding the shooter, in a public space. (The federal government reduced its definition to three victims in 2013.) This list relies on the federal definition at the time that the attack took place. We compiled the names of these 82 attacks using public records and contemporaneous news accounts. If you believe any of the names or ages are wrongly recorded, please contact us at feedback@time.com.

Rosalie Chan, David Johnson, Emma Ockerman & Justin Worland, *Why Did They Die?*, TIME, http://time.com/mass-shootings-victims/ (last visited June 19, 2021).

[22] For example, reports indicate that there was evidence of prior psychological problems known to have afflicted the shooter in the Sandy Hook Elementary School mass shooting in Newton, Connecticut, on December 14, 2012. *See* Lauren Fox, *Report: Sandy Hook Shooter Adam Lanza Was Obsessed with Mass Shootings*, US NEWS (Nov. 25, 2013), http://www.usnews.com/news/articles/2013/11/25/report-sandy-hook-shooter-adam-lanza-was-obsessed-with-mass-shootings. The report noted:

> Lanza struggled with mental illness, a history of obsessive-compulsive behaviors and a fascination with mass shootings—particularly the 1999 school

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calls for greater regulation of firearms, has traditionally argued that mentally-impaired individuals are excluded from Second Amendment protections and that more aggressive identification of those individuals would prevent many acts of gun violence.[23] Ironically, among the first important actions taken by the Republican-dominated Congress following the 2016 national election was the reversal of an Obama administration policy limiting access to gun purchases for individuals who had been determined to have mental disorders.[24] As Americans struggle with these scenes of violence and seek solutions, the role of mental health professionals in identifying potential perpetrators and preventing otherwise irrational acts of mass violence[25] has necessarily become the subject of debate.[26]

> shooting in Columbine, Colo., the report said. Yet, none of the mental health specialists he had a record of meeting with predicted he was capable of lashing out violently. While Lanza had seen professionals for his mental issues, but declined medicines prescribed to help him manage his symptoms.

Id.

[23] The National Rifle Association (NRA), the nation's most powerful lobby supporting individual gun ownership, has focused on the relationship between mental illness and gun violence through its Institute for Legislative Action. *See Mental Health and Firearms*, NAT'L RIFLE ASS'N-INST. FOR LEGIS. ACTION (Jan. 24, 2013), www.nraila.org/articles/20130124/mental-health-andrms (citing *The Mentally Ill*, AM. RIFLEMAN, Sept. 1966). The NRA position has been consistent and has been included in proposed congressional legislation, as reported by PBS. Harvi Svreenvihasan, *NRA-backed Bill Aims To Keep Guns from Mentally Ill*, PBS (Aug. 8, 2015), http://www.pbs.org/newshour/bb/nra-backed-bill-aims-keep-guns-mentally-ill/.

[24] Ali Vitali, *Trump Signs Bill Revoking Obama-Era Gun Checks for People with Mental Illnesses*, NBC NEWS (Feb. 28, 2017), http://www.nbcnews.com/news/us-news/trump-signs-bill-revoking-obama-era-gun-checks-people-mental-n727221; Editorial Bd., *Congress Says, Let the Mentally Ill Buy Guns*, N.Y. TIMES (Feb. 15, 2017), https://www.nytimes.com/2017/02/15/opinion/congress-says-let-the-mentally-ill-buy-guns.html.

[25] Of course, the fact that acts of mass violence may be perceived as *irrational* by observers, even those trained in evaluating intellectual or emotional motivation, may well simply reflect a failure to perceive motivations that are understood as *rational* by their perpetrators.

[26] Consider the position advanced by Charles Peters, founding editor of the *Washington Monthly*:

> I am a supporter of stringent gun control, but I am troubled by the conviction of some pro-control advocates that their position is somehow weakened by conceding that serious mental health problems contribute to the violence. The Gabby Giffords shooting in Tucson, the shooting at the Aurora movie theater in Denver, and the shooting at the primary school in Newtown were all committed by men who were quite obviously mentally ill.
>
> Years ago, after we had been shocked by movies like The Snake Pit, we decided to deinstitutionalize the mentally ill, but as the psychiatrist Fuller Torrey pointed out in these pages a decade ago, we neglected to fund enough

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However, even when the evidence suggests a perpetrator acted out of some mental impairment, that explanation will not likely be translated into a legal excuse for the act in terms of insanity.[27] The formulation in *M'Naghten*, the touchstone for most theories of insanity adopted by American jurisdictions, requires an actor to prove that he did not understand the nature of his acts or that he could not distinguish right from wrong.[28] An expanded theory included in the Model Penal Code definition of the offense recognizes that insanity may be evidenced by the actor's inability to conform his behavior to the requirements of the law,[29] but this legal theory of insanity has not been adopted by all jurisdictions and is not available in federal prosecutions.[30] Moreover, the compromised mental state of the accused also

> outpatient mental health clinics. Those that were funded tended to favor the easier-to-treat neurotics, rather than the more difficult, potentially violent patients. And few of us have wanted to face the difficult problem of how to compel the potentially violent to take the necessary medication.

Charles Peters, *McCruzyism . . . Too Big to Jail . . . Wake up, Democrats*, WASH. MONTHLY, Mar.–Apr. 2013, https://washingtonmonthly.com/magazine/marchapril-2013/mccruzyism-too-big-to-jail-wake-up-democrats/.

[27] The States are accorded substantial discretion in defining criminal offenses and recognizing defenses and affirmative defenses applicable in responding to charges of criminal violations. Patterson v. New York, 432 U.S. 197 (1977). No state has been required to recognize a defense based on mental illness, or insanity, and any jurisdiction that does afford the accused the option of defending on mental impairment grounds has broad discretion to define the parameters of the insanity defense applicable in prosecutions for violation of criminal offenses. *Id.* The issue of whether an accused must be accorded a defense based upon impaired mental state, however, is before the Supreme Court in *Kahler v. Kansas*, No. 18-3165, *cert. granted*, 139 S. Ct. 1318 (2019), *case below*, *State v. Kahler*, 410 P.3d 105 (Kan. 2018).

[28] 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (1843). The rule arose from the attempted killing of English Prime Minister Robert Peel by M'Naghten, who believed Peel wanted to kill him. *Id.* M'Naghten shot Peel's secretary by mistake and at trial, offered medical experts who testified that he was psychotic, leading to his acquittal by reason of insanity. *Id.* Public outcry over the verdict led to formulation of a rule governing the defense by the Lords of Justice of the Queen's Bench. Jodie English, *The Light Between Twilight and Dusk: Federal Criminal Law and the Volitional Insanity Defense*, 40 HASTINGS L.J. 1, 7 n.26 (1988).

[29] MODEL PENAL CODE § 4.01(1) (AM. LAW INST. 2019) ("A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of law.").

[30] The federal insanity defense, 18 U.S.C. § 17 (2018), does not permit reliance on psychiatric evidence of mental impairment to establish a defense not based upon inability to distinguish right from wrong. The federal statute limits insanity to proof, by clear and convincing evidence, *id.* at (b), that the defendant "was unable to appreciate the nature and quality or the wrongfulness of his acts. Mental disease or defect does not otherwise constitute a defense." 18 U.S.C. § 17(a) (2018). The federal statute frames the "right from wrong" test in terms of the inability to "appreciate the nature and quality or the wrongfulness of his acts."

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typically only affords an accused reliance on the defense when the cause of the impairment is a qualifying "mental disease or defect."[31] Thus, the Model Penal Code excludes mental impairment diagnosed as an antisocial personality disorder, for instance.[32] To the extent that references to the mass shooter's "mental illness" inaccurately include mischaracterization of less common ideological or religious beliefs or personality disorders,[33] these factors would likely not qualify the

[31] *See, e.g.*, ARK. CODE ANN. § 5-2-107(a) (2020):

> (7)(A) "Mental disease or defect" means a:
> (i) Substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life;
> (ii) State of significantly subaverage general intellectual functioning existing concurrently with a defect of adaptive behavior that developed during the developmental period; or
> (iii) Significant impairment in cognitive functioning acquired as a direct consequence of a brain injury or resulting from a progressively deteriorating neurological condition. . . .

[32] MODEL PENAL CODE § 4.01(2) (AM. LAW INST. 2019) ("As used in this Article, the terms 'mental disease or defect' do not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct."). Similarly, ARK. CODE ANN. § 5-2-301(7)(B) (2020) provides:

> (B) As used in the Arkansas Criminal Code, "mental disease or defect" does not include an abnormality manifested only by:
> (i) Repeated criminal or otherwise antisocial conduct;
> (ii) Continuous or noncontinuous periods of intoxication, as defined in § 5-2-207(b)(1), caused by a substance such as alcohol or a drug; or
> (iii) Dependence upon or addiction to any substance such as alcohol or a drug;

In *Montana v. Egelhoff*, the Court held that a state is not required to recognize voluntary intoxication as a basis for a defense due to impairment compromising the defendant's ability to form the required intent for proof of the offense. 518 U.S. 37 (1996).

[33] *See* Emily Campbell, *The Psychopath and the Definition of "Mental Disease or Defect" Under the Model Penal Code Test of Insanity: A Question of Psychology or a Question of Law?*, 60 NEB. L. REV. 190 (1990). Personality disorders do not constitute mental illness. The most common diagnoses of personality disordered individuals likely to fit mass murderers would be that they exhibit antisocial personality disorder. This disorder is characterized by antisocial behavior such as: deceiving others for personal gain; committing crimes; disregarding rules or the safety of others; acting impulsively or aggressively; acting coldly toward others; lying about big and little things; having few, if any, close relationships; having trouble keeping a job or doing schoolwork; or taking unneeded risks. Smitha Bhandari, M.D., *How Sociopaths and Psychopaths Are Different*, WEBMD (Dec. 7, 2020), https://www.webmd.com/mental-health/psychopath-sociopath-differences#1. For more on the more specific diagnosis of "psychopath," a similar characterization even more likely to describe mass murderers, see Paul Babiak, M.S., Ph.D et al., *Psychopathy: An Important Forensic Concept for the 21st Century*, FBI L. ENFORCEMENT BULL. (July 1, 2012), https://leb.fbi.gov/articles/featured-articles/psychopathy-an-important-forensic-concept-for-the-21st-century ("If psychopaths commit a homicide, their killing likely

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perpetrator for a legitimate, or successful, claim of insanity in the absence of evidence that the shooter acted while psychotic. Even when the accused claiming mental impairment can establish its existence through expert testimony, the jurisdiction's defense may not include recognition of the mental illness or impairment as an excuse based upon its approach on limiting the defense.[34]

Evidence that the perpetrator of an act of mass violence planned the offense; prepared to commit the act by acquiring semi-automatic weapons; engaged in stealthy access to the location of the planned attack; and attempted to conceal the attack; or, as in many cases, made a pre-determined decision to be killed or commit suicide following the attack may all lead jurors to reject a claim of insanity or other impairment. Instead, jurors may infer that the perpetrator's ability to distinguish right from wrong, or appreciate the wrongfulness or criminality of the planned action, was not compromised by mental illness or defect. Any of these kinds of fact may lead a jury simply to reject expert psychiatric opinion that the perpetrator was insane at the

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will be planned and purposeful, not the result of a loss of emotional control; their motive more commonly will involve sadistic gratification."). The FBI study also reports:

> Psychopathy is not a diagnosis. About one-third of individuals in prison deemed "antisocial personality disordered," the current official Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for the chronically antisocial, will meet the criteria for severe psychopathy. In DSM's upcoming fifth edition, psychopathy will become one of five dimensions for describing a personality disorder, receiving the official diagnostic blessing of American psychiatry after approximately one-half century of research.

[34] For example, in *Clark v. Arizona*, the Court rejected a challenge to the limitation on use of expert opinion on the issue of Clark's impairment, consistently diagnosed as paranoid schizophrenia manifested by his belief that alien entities were determined to kill him while posing as law enforcement officers. 548 U.S. 735, 745 (2006). Clark was charged with first degree murder and hospitalized for two years in order for treating psychiatrists to restore him to competence for trial. *Id.* at 743. While there was consensus in the diagnosis and his delusion was found credible by the testifying experts, Clark could not demonstrate that he was unable to distinguish right from wrong in committing the homicide. *Id.* at 745–46. His argument that psychiatric opinion demonstrated an excuse, in constitutional terms, was rejected in light of Arizona's limitation imposed on mental state evidence that recognizes only insanity when the actor cannot distinguish right from wrong. Thus, his claim that the evidence was admissible to demonstrate that he lacked the specific intent to commit murder, a necessary element of proof in the prosecution's case, failed under Arizona law. *Id.* at 743. In contrast, in *Kahler v. Kansas*, the Court upheld the alternative approach adopted by Kansas, in which ability to distinguish right from wrong plays no role in excusing the accused's conduct, limiting its mental state defense to proof that the accused could not form the element or degree of criminal intent to demonstrate that they acted with the required culpable mental state for commission of the offense charged. 140 S. Ct. 1041, 1025–26 (2020).

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time of the commission of the act of mass violence, moreover, and the jury's rejection of an insanity defense will typically be upheld.[35]

In a mass shooting case that did come to trial involving the attack by a lone gunman in an Aurora, Colorado movie theater in 2012, the insanity defense failed in a rather atypical situation—one in which the perpetrator did not die as a result of suicide or gunfire from law enforcement officers.[36] The shooting occurred during a midnight showing of the Batman film *The Dark Knight Rises*, during which the shooter, James Holmes, fired randomly, killing twelve and injuring seventy filmgoers.[37] Holmes admitted to the killings and pleaded not guilty based on insanity.[38] The defense offered a plea of guilty in return for the prosecution's waiver of the death penalty,[39] but the State declined and the case proceeded to trial. The jury

[35] *See, e.g.*, Moore v. Duckworth, 443 U.S. 713 (1979) (no violation of due process if jurors reject even uncontroverted forensic opinion that defendant was insane); Davasher v. State, 823 S.W.2d 863, 872 (Ark. 1992) ("In support of the verdict, the State argues there was evidence that Davasher bought a machete six months before the crime, that he attempted to wash his clothes after the crime to remove incriminating evidence, and that he burned his hands so the police would have trouble obtaining his fingerprints. These steps taken to avoid identification as the culprit indicate Davasher was cognizant of his wrongdoing at the time the crime was committed.").

[36] The recent release of the film JOKER (Warner Bros. Pictures 2019) prompted family members of victims of the 2012 shooting to protest the showing of the film in Aurora because of fears the violence in the film would again traumatize the community. *See* Sandra Gonzalez, *Families of Aurora Theater Shooting Victims Ask Movie Studio to Take Action Ahead of 'Joker' Release*, CNN (Sept. 25, 2019), https://www.cnn.com/2019/09/24/entertainment/joker-aurora-warner-bros/index.html.

[37] Clayton Sandell, Carolyn McKinley & Christina Ng, *James Holmes' Insanity Plea Accepted by Court in Colorado Theater Massacre*, ABC NEWS (June 14, 2013), http://abcnews.go.com/US/james-holmes-insanity-plea-accepted-court-colorado-theater/story?id=19320525.

[38] John Ingold, *James Holmes' Insanity Plea Faces Historically Long Odds*, DENVER POST (June 6, 2013), https://www.denverpost.com/2013/06/06/james-holmes-insanity-plea-faces-historically-long-odds/. The *Denver Post* news story includes the interesting observation:

> In pleading not guilty by reason of insanity, James Holmes is trying to do something no accused mass shooter in America has done in more than 20 years: win a mental-health case.
> He will do it in a state that is one of only a handful in the country to put the burden of proving a defendant's sanity on the prosecution. Even so, Holmes faces long odds for a defense that studies show is raised in only about 1 percent of all felony cases nationally and successful in only about a quarter of those.

Id.

[39] John Ingold, *James Holmes' May Plead Guilty to Avoid the Death Penalty, Court Documents Show*, DENVER POST (Mar. 27, 2013), http://www.denverpost.com/2013/03/27/james-holmes-may-plead-guilty-to-avoid -death-penalty-court-documents-show/.

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rejected the insanity plea but imposed a life sentence on each murder count during sentencing.[40] Even before Holmes was convicted and sentenced, another theater shooting occurred in which two patrons were fatally shot and nine others wounded before the shooter committed suicide in Louisiana.[41]

More recently, mass murders involving shootings have focused on political or ideological motives or explanations for resorting to publicly dramatic incidents of violence. For instance, the shooting at the Republican Congressional baseball practice was apparently precipitated by political opposition and anger directed at the election of President Trump.[42] The shootings at the Charleston, South Carolina Emanuel African Methodist Episcopal Church on June 17, 2015, took the lives of nine African-American victims, renewing the threat of domestic terrorism grounded in the perpetrator's white supremacist ideology.[43] Later, the San Bernardino,

[40] James Steffen, *James Holmes Sentenced to Life in Prison in the Aurora Theater Shooting*, DENVER POST (Aug. 7, 2015), http://www.denverpost.com/2015/08/07/james-holmes-sentenced-to-life-in-prison-in-the-aurora-theater-shooting/.

[41] Leslie Turk & Liam Stack, *Gunman Kills 2 and Himself in Shooting at Movie Theater in Lafayette, Louisiana*, N.Y. TIMES (July 23, 2015), http://www.nytimes.com/2015/07/24/us/shooting-at-lafayette-la-movie-theater.html. The suspect's journal was subsequently released publicly and revealed antipathy toward women, LGBTQ individuals, and Black minorities, mentioning presidential candidates including Donald Trump, and praise for Dylann Roof, the suspect arrested in the shooting a month earlier at a Charleston, South Carolina church. *Id.* Additionally, reporting included a reference to an episode in 2008 in which the Lafayette gunman, John Russell Houser, a 59-year-old drifter in which his relatives petitioned a Georgia court to order a mental evaluation for him, but later declined to order him involuntarily committed, perhaps enabling him to pass a federal background check in 2014 when he legally purchased the .40 caliber handgun used in the theater shooting. Michael Kunzelman & Rebecca Santana, *No Clear Motive Seen in Louisiana Theater Shooter's Journal*, ASSOCIATED PRESS (Jan. 14, 2016), http://www.apnewsarchive.com/2016/No_clear_motive_seen_in_Louisiana_theater_shooter%27s_journal/id-948fa33ea4af4dc38ff18900cb1f6bd9.

[42] *See* Michael D. Shear, Adam Goldman & Emily Cochrane, *Steve Scalise Among 4 Shot at Baseball Field; Suspect Is Dead*, N.Y. TIMES (June 14, 2017), https://www.nytimes.com/2017/06/14/us/steve-scalise-congress-shot-alexandria-virginia.html (detailing shooting of U.S. Representative Steve Scalise, R., Louisiana, Congressional aide, lobbyist and two police officers by self-described supporter of Senator Bernie Sanders' 2016 bid for the Democratic Presidential nomination for President, apparently based on the shooter's political views).

[43] Matt Ford & Adam Chandler, *'Hate Crime': A Mass Killing at a Historic Church*, ATLANTIC (June 19, 2015), https://www.theatlantic.com/national/archive/2015/06/shooting-emanuel-ame-charleston/396209/. A state senator was one of the victims in the shooting that occurred at an historic African Episcopal Methodist Church committed by Dylann Roof, proclaimed allegiance to white supremacist ideology, reportedly reloading his revolver five times and telling a survivor: "I have to do it. . . . You rape our women and you're taking over our country. And you have to go." *Id.* Roof reportedly sat through part of the church service prior to opening fire, later claiming that he did not suffer from a mental illness and representing himself at his capital sentencing hearing, being sentenced to serve nine life sentences. The Associated Press, *Dylann Roof Appeals Death Penalty in South Carolina Church Massacre*, NBC NEWS

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California,[44] and Orlando, Florida shootings,[45] as well as the Boston Marathon bombing,[46] have forced authorities to respond to the threat of internationally-based terrorist activity prompted by the allegiance of perpetrators to radical Islam and ISIL.[47] A particularly surprising attack involved the mass murder of military

(Jan. 29, 2020, 7:59 AM), https://www.nbcnews.com/news/us-news/dylann-roof-appeals-death-penalty-south-carolina-church-massacre-n1125341.

[44] *See, e.g.*, Josh Sanburn, *Why the San Bernadino Shooting is Unprecedented*, TIME (Dec. 3, 2015), http://time.com/4135049/san-bernardino-shooting-psychology/. The couple who committed the mass shooting of a social services center where the husband was employed killed fourteen people, apparently randomly targeted, and apparently as a result of radical Islamic ideological leanings. Michael S. Schmidt & Richard Pérez-Peña, *F.B.I. Treating San Bernardino Attack As Terrorism Case*, N.Y. TIMES (Dec. 4, 2015), https://www.nytimes.com/2015/12/05/us/tashfeen-malik-islamic-state.html.

[45] *See* Ariel Zambelich & Alyson Hurt, *3 Hours In Orlando: Piecing Together An Attack and Its Aftermath*, NPR (June 26, 2016), https://www.npr.org/2016/06/16/482322488/orlando-shooting-what-happened-update. *The Guardian* reports, in response to the mass shooting at a nightclub in Orlando, Florida, that occurred on June 13, 2016:

> Sunday's attack on the Pulse nightclub in Orlando, Florida was the deadliest mass shooting in American history—but there were five other mass shootings in the US during that weekend alone.
> "We have a pattern now of mass shootings in this country that has no parallel anywhere else in the world," Barack Obama said after the San Bernardino attack in December 2015.
> Data compiled by the Gun Violence Archive reveals a shocking human toll: there is a mass shooting—defined as four or more people shot in one incident, not including the shooter—on five out of every six days, on average.

1000 Mass Shootings in 1230 Days: This is What America's Gun Crisis Looks Like, GUARDIAN, http://www.theguardian.com/us-news/ng-interactive/2015/oct/02/mass-shootings-america-gun-violence (last updated June 13, 2016).

[46] *See Boston Marathon Bombings*, HISTORY (Mar. 28, 2014), http://www.history.com/topics/boston-marathon-bombings (last updated June 7, 2019) (summarizing bombing of Boston Marathon race, when two brothers planted bombs killing three spectators and injuring more than 260 others, believed to be related to radical Islamic ideological leanings).

[47] *See, e.g.*, Devlin Barrett, Matt Zapotosky & Mark Berman, *New York Truck Attack Suspect Charged with Terrorism Offense as Trump Calls for a Death Sentence*, WASH. POST (Nov. 2, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/11/01/new-york-attack-probe-expands-to-uzbekistan-as-possible-militant-links-explored/?utm_term=.1198e58a0673 (Early reports relating to the fatal assault on a New York City parkway by a driver of a rented truck, killing eight, suggested a terroristic motivation as he yelled "'Allahu akbar' meaning 'God is Great,'" upon fleeing from the truck before being shot by a New York police officer.). Police recovered other evidence of terrorist motivation:

> Investigators found on Saipov's phones 90 videos and 3,800 images, many of which seemed to be Islamic State propaganda, videos of the group's fighters killing prisoners or bomb-making instructions. He told agents that he wanted to kill as many people as he could and considered putting Islamic State flags

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personnel by a U.S. Army psychiatrist, Major Nidal Malik Hasan, who killed thirteen and wounded thirty in the attack, including two civilians, on November 5, 2009, at Fort Hood, Texas.[48] The assailant, an adherent of the Muslim faith, apparently acted out of anxiety over being deployed to Afghanistan, where he would be forced to fight other Muslims.[49] The shooter later declared that he committed the murders to protect Taliban leaders. This led to questions about whether the Army's characterization of the attack as an act of "workplace violence" was accurate, instead of it being labeled an act of "terrorism."[50]

Apart from the significance attached to the motivation of perpetrators of mass violence—typically shootings or bombings—the most concerning aspect of the increasing public interest attached to these acts has been the fact that recent events often involve randomly selected victims targeted in public locations. Among the most tragic and publicly distressing of these events have been shootings at educational institutions. School shootings have been prominent over the past two decades, including the killings at the following institutions:

> ● At Santa Fe, Texas, ten high school students were killed and thirteen wounded by a student using a pump shotgun and revolver on May 18, 2018. The seventeen-year-old shooter had no apparent history of mental illness but reportedly had shown an interest in the alt-right and neo-Nazism.[51]
>
> ● The February 14, 2018—Valentine's Day—mass shooting at Marjorie Stoneman Douglas High School in Parkland, Florida, resulted in seventeen deaths

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> at the front and back of his truck—but ultimately decided it would draw too much attention, court papers say.

Id.

[48] Robert D. McFadden, *Army Doctor Held in Ft. Hood Rampage*, N.Y. TIMES (Nov. 6, 2011), http://www.nytimes.com/2009/11/06/us/06forthood.html.

[49] James Dao, *Suspect Was 'Mortified' About Deployment*, N.Y. TIMES (Nov. 6, 2009), http://www.nytimes.com/2009/11/06/us/06suspect.html.

[50] Manny Fernandez & Alan Blinder, *At Fort Hood, Wrestling with Label of Terrorism*, N.Y. TIMES (Apr. 8, 2014), https://www.nytimes.com/2014/04/09/us/at-fort-hood-wrestling-with-label-of-terrorism.html. Major Hasan was prosecuted on a charge of murder, rather than terrorism, which had significant implications for victims, as the *New York Times* article explained: "The issue stretches far beyond semantics. The lack of a terrorism declaration prevents victims from receiving combat-related benefits and Purple Hearts. It has also become a politicized issue." *Id.*

[51] Julie Turkweitz & Jess Bidgood, *Who Is Dimitrios Pagourtzis, the Texas Shooting Suspect*, N.Y. TIMES (May 18, 2018), https://www.nytimes.com/2018/05/18/us/dimitrios-pagourtzis-gunman-texas-shooting.html.

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and seventeen individuals being wounded by a former student at the school, Nicholas Cruz, who used a semi-automatic pistol in the attack. Cruz had a documented history of emotional problems and intervention by school and social service professionals due to behavior described as "moody, impulsive, angry, attention seeking, annoy[ing to] others on purpose and threaten[ing] to hurt others."[52]

● Community college students were victims of a mass shooting at Umpqua Community College in Oregon, where a student, reacting to criticism by a teacher, shot and killed him and eight other students on October 1, 2015.[53]

● Twenty schoolchildren and six teachers were shot at Sandy Hook Elementary School in New Town, Connecticut, on December 14, 2012,[54] by a twenty-year-old individual suspected of suffering from serious mental health problems.[55]

● College students were also killed at Virginia Tech Polytechnic Institute and State University, Blacksburg, Virginia, where thirty-two victims, twenty-seven students and five teachers, were killed on the campus on April 16, 2007, before the shooter, who was described as a "loner" with "mental health problems," killed himself.[56]

● Twelve high school students and one teacher, with more than twenty other victims, were shot at Columbine High School in Colorado, on April 20, 1999, by

[52] Olmeda, *supra* note 8.

[53] Julie Turkowitz, *Oregon Gunman Smiled, Then Fired, Student Says*, N.Y. TIMES (Oct. 10, 2015), https://www.nytimes.com/2015/10/10/us/roseburg-oregon-shooting-christopher-harper-mercer.html. The shooting at the college in Roseburg, Oregon, left one professor and eight students dead. *Id.* Three years earlier, another shooting at Clackamas (Oregon) Towncenter Mall resulted in the death of two patrons. Catherine E. Shoichet & Michael Martinez, *3 dead in Oregon mall shooting*, CNN (Dec. 11, 2012), http://www.cnn.com/2012/12/11/us/oregon-mall-shooting/. The shooter used an AR-15 rifle in the apparently random attack. *Id.* The 2015 college shooting was reportedly the fifth in Oregon since 1998. Capi Lynn, *Timeline of mass shootings in Oregon*, STATESMAN J. (Oct. 13, 2015), http://www.statesmanjournal.com/story/news/2015/10/02/mass-shootings-oregon-umpqua-roseburg/73163304/.

[54] *Sandy Hook Shooting: What Happened?*, CNN, http://www.cnn.com/interactive/2012/12/us/sandy-hook-timeline/index.html (last visited Nov. 13, 2020).

[55] Aaron Katersky & Suzanna Kim, *5 Disturbing Things We Learned Today About Sandy Hook Shooter Adam Lanza*, ABC NEWS (Nov. 21, 2014), http://abcnews.go.com/US/disturbing-things-learned-today-sandy-hook-shooter-adam/story?id=27087140.

[56] *Massacre at Virginia Tech Leaves 32 Dead*, HISTORY (Apr. 13, 2011), http://www.history.com/this-day-in-history/massacre-at-virginia-tech-leaves-32-dead (last updated Apr. 14, 2020).

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> two shooters, aged seventeen and eighteen, who then turned the guns on themselves and committed suicide.[57]

The use of public venues for the expression of personal disaffection or political ideology is particularly troubling because it suggests, both in the openness of the forum and in the apparent randomness of choice of victims, a threat to personal and public security that casts doubt on the safety of modern life, of shopping at the mall[58] or attending a public event, such as the bombing of the concert attracting a largely younger audience in Manchester, England.[59]

The evolution of "mass violence" as a commonly-referenced concept has itself required re-thinking what the term means. A *Washington Post* article noted this semantic reality, addressing the alternative uses of the term, and the term "mass shooting," in its opening paragraphs:

> On Thursday, a gunman shot and killed three people and injured 14 more in Hesston, Kan., before he was killed by police.
>
> It was the 49th mass shooting of 2016.
>
> No scratch that, it was the 33rd mass shooting.
>
> It's said that the Inuit people have 50 words for snow. Sometimes it seems like Americans have nearly as many definitions for "mass shooting." Which definition is correct? They all are—it just depends on what you want to measure.
>
> Let's start with the most restrictive one, from the shooting tracker maintained by Mother Jones magazine. According to these criteria, a shooting becomes a mass shooting if the gunman kills four or more people (excluding himself); if he acts alone; and if the shootings take place in public, including workplaces, schools, churches and the like.[60]

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[57] *Columbine Shooting*, HISTORY (Nov. 9, 2009), http://www.history.com/topics/columbine-high-school-shootings (last updated Mar. 30, 2020). This incident inspired the 2003 Academy Award Oscar-winning documentary film, BOWLING FOR COLUMBINE (United Artists 2002).

[58] *See* Shoichet & Martinez, *supra* note 53.

[59] *The Latest on the Manchester Bombing Investigation*, N.Y. TIMES (May 24, 2017), https://www.nytimes.com/2017/05/24/world/europe/manchester-uk-bombing-live.html (compendium of articles reported in the *New York Times* relating to the aftermath of the bombing of concert attracting young people and children in a Manchester, England arena on May 22, 2017).

[60] Christopher Ingraham, *We Have Three Different Definitions of 'Mass Shooting,' and Probably Need More*, WASH. POST (Feb. 26, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/02/26/we-have-three-different-definitions-of-mass-shooting-and-we-probably-need-more/.

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The continuing focus on the motivation of those who commit acts of mass violence, particularly involving firearms, requires consideration of the nature of the violent acts themselves and their likely sources. The rise of acts of terrorism, evidenced by the San Bernadino[61] and Orlando nightclub[62] shooting cases and the bombing of the Boston Marathon, have added to a range of acts of mass violence that complicate the framework for considering the roles of mental illness, or personality disorders, or both, in precipitating the kind of carnage now seemingly routine, or commonplace.

The emergence of terrorism as a prime motivating factor in acts of mass violence adds to the complexity, suggesting the relationship between deep psychological defects and the gravitation of the impaired to radical thinking.[63] The motivation of those attracted to the political fringe is likely linked to intense paranoia, perhaps inspiring acts of domestic terrorism, such as the Oklahoma City bombing by white nationalists advocating violent opposition to the national government,[64] and international terrorism motivated by eschatological extremism. Regardless, the rise of mass acts of terrorist violence adds to the difficulties facing

[61] *See* Sanburn, *supra* note 44.

[62] Zambelich & Hurt, *supra* note 45. The *Washington Post* noted the following in regard to the shooter's possible motivation: "The FBI has found no evidence so far that Omar Mateen, who killed 49 people and wounded more than 53 at the Pulse nightclub in Orlando, chose the popular establishment because of its gay clientele, U.S. law enforcement officials said." Adam Goldman, *FBI Has Found No Evidence That Orlando Shooter Targeted Pulse Because It Was a Gay Club*, WASH. POST (July 16, 2016), https://www.washingtonpost.com/world/national-security/no-evidence-so-far-to-suggest-orlando-shooter-targeted-club-because-it-was-gay/2016/07/14/a7528674-4907-11e6-acbc-4d4870a079da_story.html.

[63] For instance, in the wake of the mass shooting at the Orlando nightclub frequented by gay patrons, speculation emerged that the shooter, Omar Mateen, was influenced by his prior visits to the nightclub and experience with an internet chat and dating site frequented by homosexuals. *See* Molly Hennessy-Fiske, Jenny Jarvie & Del Quentin Wilber, *Orlando Gunman Had Used Gay Dating App and Visited LGBT Nightclub on Other Occasions, Witnesses Say*, L.A. TIMES (June 13, 2016), http://www.latimes.com/nation/la-na-orlando-nightclub-shooting-20160613-snap-story.html. The speculation that there was a connection between his Muslim world view and suspected homosexual tendencies, perhaps leading to the mass shooting, was heightened by reporting that his former wife believed he was latently homosexual and that he had been admonished by his strict Muslim father against homosexuality. *See* Chris Perez & Joe Tacopino, *Ex-Wife's Bombshell Claim: Club Shooter Was Gay*, N.Y. POST (June 13, 2016), http://nypost.com/2016/06/13/shooter-used-to-visit-orlando-gay-club-use-gay-dating-apps/. However, other investigation apparently has found no link between the shooter's motivation and homophobia. *See* Goldman, *supra* note 62.

[64] *See Oklahoma City Bombing*, FBI HISTORY: FAMOUS CASES & CRIMINALS, https://www.fbi.gov/history/famous-cases/oklahoma-city-bombing (last visited July 14, 2020); *Oklahoma City Bombing*, HISTORY (Dec. 16, 2009), https://www.history.com/topics/1990s/oklahoma-city-bombing.

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ordered societies in addressing the motivations that lead to these events, which include bombings, mass shootings, use of vehicles to inflict injury and damage,[65] and individual random acts of violence, such as apparently unprovoked stabbings.[66]

The role of mental disease or defect in provoking individuals to commit acts of mass violence will continue to be a critical element for investigators seeking to understand the motivation of perpetrators.[67] For those perpetrators not killed in the tragedies of their own making, the issue of causation will bear on the approach taken by prosecutors and defense counsel in the criminal process in which issues of culpability and guilt will be determined. But these concerns do not address the key question asked in many of these episodes of violence: could anything have been done to prevent these acts of mass violence? In the context of recent history, that will likely be the second question asked, following the initial inquiry as to whether the violence is linked to terrorism.

When evidence of prior mental illness or disturbance is raised during the investigation of an act of mass violence, or when the perpetrator has been identified,

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[65] These types of attacks are not limited to the United States, of course, with perhaps the most devastating having occurred in Nice, France, on July 14, 2017, resulting in death to at least 86 people and injuring 202 more, when a Tunisian born driver rammed his truck into a "Bastille Day" celebration. *See, e.g.*, Alan Yuhas et al., *Nice Attack: Truck Driver Named as France Mourns 84 Killed in Bastille Day Atrocity—as It Happened*, GUARDIAN (July 15, 2016), https://www.theguardian.com/world/live/2016/jul/14/nice-bastille-day-france-attack-promenade-des-anglais-vehicle. The report relating to the perpetrator includes the following information initially obtained:

> [Mohamed Lahouaie] Bouhlel was known to police because of allegations of threats, violence and thefts over the last six years, and he was given a suspended six-month prison sentence this year after being convicted of violence with a weapon, Molins said.
> Bouhlel's father, who lives in Tunisia, has revealed that his son showed signs of mental health issues—having had multiple nervous breakdowns and volatile behavior, said CNN terrorism analyst Paul Cruickshank.

CNN, *Attack in Nice: Truck Driver Identified as 31-Year-Old Tunisia Native*, GANT NEWS (July 15, 2016), https://gantdaily.com/2016/07/15/attack-in-nice-truck-driver-identified-as-31-year-old-tunisia-native/. The report reflects the suspected link between mental impairment and some terrorist inclinations, highlighted by repeated violent acts prior to the terrorist attack involving mass violence. *Id.*

[66] *See, e.g.*, Doug Brown, *Suspect in Portland Hate Crime Murders Is a Known White Supremacist*, PORTLAND MERCURY (May 27, 2017), http://www.portlandmercury.com/blogtown/2017/05/27/19041594/suspect-in-portland-hate-crime-murders-is-a-known-white-supremacist.

[67] One source offers a breakdown of incidence of mental illness in the history of mass shooters. The statistical breakdown for mass shootings surveyed over the period from 1982 through August 2019, shows that in 58 of the incidents the shooter had some evidence or signs of mental problems; that in 24 cases it was unclear whether there had been evidence of prior mental problems; that in 17 cases there was no evidence of prior mental problems; and in 16 cases, it incidence of prior mental health problems could not be determined. *See* Follman et al., *supra* note 19.

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the relevant questions will necessarily focus on a history of diagnosis or treatment. At that point, the next inquiry will be whether the mental health professional, who may have been aware of the threat or potential for violence, should have taken precautions to prevent injury to others by their patient.

However, the realities of acts of mass violence suggest that this expectation—that warnings about potential violence by dangerous patients will serve to provide significant protection against these acts—must likely be viewed as unrealistic. Nevertheless, the question of responsibility for prevention has been framed with respect to the duty of the mental health professionals, as Professor Mark Rothstein explains:

> After recent tragedies involving mass murders on a college campus in Virginia, an Army base in Texas, a congressional constituent event at a shopping center in Arizona, and a movie theater in Colorado, one might have assumed the public had become numb to horrendous and senseless acts of killing. If so, one would have been wrong. The public was not prepared for the brutal and cold-blooded murder of 20 first-grade school children and six teachers and staff at Sandy Hook Elementary School in Newtown, Connecticut, on December 14, 2012.
>
> Following the all-too-familiar emotional stages of shock, grief, and anger, many members of the public and elected officials turned to the issue of how to prevent such tragedies in the future. Two main questions quickly became the focus of policy makers. First, is it politically feasible and practically effective to restrict access to military-style assault weapons and large-capacity magazines that enable these mass murders? Second, is it possible for mental health professionals, family members, and others to identify serious threats and to intervene with mentally unstable individuals in time to prevent future tragedies?[68]

[68] Mark A. Rothstein, Tarasoff *Duties After Newton*, 42 J.L. MED. & ETHICS 104, 104 (2014). In this article, Professor Rothstein proposes "a strategy for developing and implementing a unitary, national standard for health care providers' privilege to disclose confidential information and their duty to protect individuals threatened by potentially violent mental health patients." *Id.* at 104. Professor Rothstein is the Herbert F. Boehl Chair of Law and Medicine and the Director of the Institute for Bioethics, Health Policy and Law at the University of Louisville School of Medicine in Kentucky. *Mark A. Rothstein*, U. LOUISVILLE, https://louisville.edu/bioethics/directory/mark-a.-rothstein.

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

> *A* psychiatric outpatient *opened fire Thursday inside a psychiatrist's office at a hospital near Philadelphia, killing his caseworker and slightly wounding the doctor, who shot the gunman with his personal firearm, authorities said.*[69]

The possibility that acts of mass violence can be addressed proactively by mental health providers in some situations rests on two related, but distinct, courses of action arising from the therapeutic relationship between patients who articulate violent threats toward others and their treating professionals. First, treatment itself may successfully address the sources of frustration, anxiety, and rage that may underlie threats that could potentially erupt in violent action. This reality does not address prevention in the way discussed with respect to those acts of mass violence that have been committed, however. Second, those professionals in a position to assess the potential for violence may also be positioned to trigger intervention to address an immediate act of violence suggested by disclosure of underlying causes of a patient's propensity for violence.

The position of the treating professional to address violent tendencies and threats of violence does not limit the role of the mental health profession in addressing the problem of violence in the aggregate, of course. Understanding and insight gained from experience and observation of patient violence may also offer particular value in advising other actors, legislators, policymakers, and law enforcement officials in their response to the situations that may give rise to violence in society, generally. But in terms of specific threats posed by individuals, those threats made in the course of therapy with mental health professionals may offer unique prospects for the prevention of violent behavior, whether through successful treatment or warnings designed to induce action appropriate for deterring the actualization of patient violence.

A. Tarasoff *and the Duty to Warn or Protect*

The duty of mental health providers to protect third persons from potential acts of violence threatened by their patients was recognized in the California Supreme

[69] Michael Winter, *Pennsylvania Doctor Shoots Patient Who Killed Caseworker*, USA TODAY (July 24, 2014), https://www.usatoday.com/story/news/nation/2014/07/24/shooting-wellness-center/13113555/ (emphasis added).

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Court's landmark decision in *Tarasoff v. University of California Board of Regents*.[70] The case arose in the initial factual context of a college student's disclosure to a psychologist at the University's Cowell Memorial Hospital on the Berkeley campus that he intended to kill his ex-girlfriend, Tatiana Tarasoff, when she returned to campus from summer vacation.[71] The psychologist directed campus police to take the patient, Prosenjit Poddar, into custody to evaluate possible involuntary civil commitment, but police decided not to do so after contacting him.[72] Once that happened, the psychologist was directed by his supervisor in the clinic not to take any further action,[73] and Tarasoff was never warned of Poddar's threat to kill her.[74] When Tatiana returned from vacation, Poddar went to her residence and killed her.[75]

The *Tarasoff* court held that statutory immunity barred the action against the mental health professionals with the University hospital[76] and police[77] based on the failure to successfully detain Poddar for further psychiatric evaluation. But, it also held that no immunity protected the psychologists and psychiatrists involved in Poddar's treatment at the health center from liability based on their failure to take appropriate action to at least warn Tatiana or her family of Poddar's threats.[78]

In considering the plaintiff's argument, the court noted that, at the common law, there was no duty for one person to control the conduct of another unless a special relationship existed warranting the finding of a duty to prevent injury. It explained, "the courts have carved out an exception to this rule in cases in which the defendant

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[70] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976), *on rehearing en banc*, 529 P.2d 553 (Cal. 1974). The *en banc* decision followed an initial decision, 529 P.2d 553 (1974), in which the court had also concluded that the treating psychologist had a duty to *warn* a third person of a patient's threat to commit an act of violence specifically identifying that person as the intended target of the threat. 529 P.2d at 559. The case was originally heard by the California Court of Appeals, which held that the defendant therapists were entitled to immunity for their failure to successfully hospitalize Poddar under then-applicable CAL. GOV. CODE §§ 820.2, 855.6; § 5150. Tarasoff v. Regents of Univ. of Cal., 108 Cal. Rptr. 878, 886–87 (Cal. Ct. App. 1973).

[71] 551 P.2d at 341.

[72] *Id.* at 339–40.

[73] *Id.* at 340.

[74] *Id.*

[75] *Id.* at 433.

[76] *Id.* at 351–52.

[77] *Id.* at 352–53.

[78] *Id.* at 340.

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stands in some special relationship to either the person whose conduct needs to be controlled or in a relationship to the foreseeable victim of that conduct."[79] Although there was no allegation that the mental health professionals had a special relationship with Tatiana that would have established that Poddar's psychologist had a direct duty toward her, the court concluded that the special relationship existing between Poddar and his psychotherapist could "support affirmative duties for the benefit of third persons."[80]

In its original framing of the duty, the California Supreme Court phrased the mental health professional's duty toward third persons as a duty to *warn* against patient violence. It described the burden imposed on the professional:

> When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning. Primarily, the relationship between defendant therapists and Poddar as their patient imposes the described *duty to warn*.[81]

In initially grounding its recognition of the cause of action for failure to warn, the *Tarasoff* majority carefully limited its holding factually to the identification of a specific victim disclosed to the mental health professional, thereby meeting the general requirement in tort law of foreseeability. It limited the scope of duty to the situation in which there is a special relationship—there, the therapeutic relationship between the therapist and the patient, Poddar—that warrants imposition of duty arising from that relationship.

While the special relationship between Poddar and the University psychologist did not include Tatiana, the majority concluded that the duty to her as an intended victim arose from that relationship. Alternatively, one might conclude that the treating psychologist had a duty to protect his patient, Poddar, from the adverse

[79] *Id.* at 343.

[80] *Id.* at 343–44. The court noted, as examples: "[A] hospital must exercise reasonable care to control the behavior of a patient which may endanger other persons. A doctor must also warn a patient if the patient's condition or medication renders certain conduct, such as driving a car, dangerous to others." *Id.* at 343–44 (citations omitted).

[81] Tarasoff v. Regents of Univ. of Cal., 529 P.2d 553, 555 (Cal. 1974), *vacated*, 551 P.2d 334 (Cal. 1976) (emphasis added).

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consequences that would flow from action taken upon his threat.[82] Poddar was convicted of Tatiana's murder[83] as a result of acting upon his threat, for instance.[84]

On rehearing, the majority reframed the test, expanding the duty beyond warning the intended victim:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. *Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger,*

[82] Psychiatry professor Bruce J. Cohen notes, in discussing the multiple functions of warning when required under the proper circumstances when other options for addressing potential patient violence are not successful:

> Notification of the police or of a potential victim ultimately still may prove to be necessary. This most likely to be the case when a significant risk to the potential victim is likely to remain despite [alternative] interventions. However, this still ideally should be turned into a *doctor-patient therapy issue* rather than simply fulfilling of a doctors ethical and legal obligations. After all, issuing a warning may actually be in the patient's best interest if it helps the patient avoid committing an impulsive act that he would later regret.

BRUCE J. COHEN, THEORY AND PRACTICE OF PSYCHIATRY 464 (2003). For discussion of alternative interventions available to address patient dangerous in appropriate circumstances, see text accompanying *infra* note 99.

[83] On direct appeal from Poddar's conviction for murder, the intermediate appellate court noted in its opinion that "three psychiatrists and one clinical psychologist agreed that appellant suffered from chronic schizoid paranoia." People v. Poddar, 103 Cal. Rptr. 84, 93 (Cal. Ct. App. 1972). The state supreme court subsequently reversed Poddar's conviction and the appellate court's decision in finding that the trial court committed prejudicial error in instructing the jury on implied malice, remanding the case for new trial. People v. Poddar, 518 P.2d 342, 344 (Cal. 1974).

[84] This does not mean, however, that Poddar could have successfully sued for breach of the therapist's duty to protect his, as a patient, from his own act of violence. The Iowa Supreme Court addressed such a claim in *Cole v. Taylor*, 301 N.W.2d 766 (Iowa 1981). The court summarized the issue: "[W]hether a patient may recover in tort from her psychiatrist on a claim that, in his professional capacity, he negligently failed to prevent her from committing murder." *Id.* at 767. The plaintiff/patient argued that her psychiatrist was negligent in failing to take appropriate action to prevent the murder of her ex-husband physician once she disclosed her threats to kill him. *Id.*

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> *to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.*[85]

The court's rephrasing of the duty includes the option of warning the potential victim of a patient's threat. But its broad language also affords the mental health professional the option of taking action other than requiring direct warning addressed to the prospective victim relating to the patient's threats.[86] Arguably, and likely, a significant issue is whether warning the prospective victim is the most effective means of offering protection. For instance, in some cases, the act of warning itself might precipitate violent behavior on the patient's part, particularly if the warning results in aggravation of patient hostility directed against the intended victim or others based on the perception that the mental health professional has betrayed the patient by disclosing information shared with the expectation of confidentiality.

Concern for the violation of the confidentiality duty prompted Justice Clark to dissent from the majority's holding in *Tarasoff*. Justice Clark predicted that an increase in actual violence could be expected to result from the warnings or other action taken by mental health professionals in their attempt to protect potential victims of patient violence.[87] The majority, by contrast, considered the significance

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[85] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976), *on rehearing en banc*, 529 P.2d 553 (Cal. 1974) (emphasis added). For an example of professional advice on the expansion of the mental health professional's duty, see Stephen E. Berger & Michael Berger, Tarasoff *"Duty to Warn" Clarified*, THE NATIONAL PSYCHOLOGIST (Mar. 1, 2009), http://nationalpsychologist.com/2009/03/tarasoff-%E2%80%9Cduty-to-warn%E2%80%9D-clarified/101056.html (last updated May 31, 2011).

[86] One commentator argued that the change in language did little to actually alter the underlying theory of the duty imposed on clinicians. *See* Paul B. Herbert, *The Duty to Warn: A Reconsideration and Critique*, 30 J. AM. ACAD. PSYCHIATRY L. 417, 418 (2002) (arguing that the change in language on rehearing, from imposing a "duty to warn" to a "duty to warn or other-wise protect" "is a distinction with little practical difference").

[87] 551 P.2d at 354, 361. Justice Clark offered a series of objections to the majority's reasoning, including the following observation:

> The warning itself is an impairment of the psychiatrist's ability to treat, depriving many patients of adequate treatment. It is to be expected that after disclosing their threats, a significant number of patients, who would not become violent if treated according to existing practices, will engage in violent conduct as a result of unsuccessful treatment. In short, the majority's duty to warn will not only impair treatment of many who would never become violent but worse, will result in a net increase in violence.

Id. at 361.

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of the confidentiality violation and opted for disclosure when necessary to prevent injury to identified potential victims.

Critical to the decision to recognize potential liability was the court's reliance on the fact that the patient's identification of a specific victim of his threats met the foreseeability test in concluding that his intent would be manifested in an act injuring her.[88] Here, the identification of Tatiana as the intended victim heightened the foreseeability that she would suffer injury and that warning of this possibility could have averted her murder. The court concluded, "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."[89]

The treating psychologist's assessment of Poddar's potential for dangerous activity was unequivocally demonstrated by the fact that he contacted police about detaining Poddar. Poddar's threats made clear that Tatiana would likely be victimized as a result of his anger.

> We recognize the public interest in supporting effective treatment of mental illness and in protecting the rights of patients to privacy . . . and the consequent public importance of safeguarding the confidential character of psychotherapeutic communication. Against this interest, however, we must weigh the public interest in safety from violent assault. The Legislature has undertaken the difficult task of balancing the countervailing concerns.[90]

[88] *Id.* at 342. Moreover, on the facts presented, the psychologist who counseled Poddar, Dr. Moore, had made the determination that Poddar represented a significant threat, as demonstrated by the fact that Dr. Moore called the police to warn them of Poddar's threats and have them pick him up for evaluation for civil commitment. *Id.* at 339–40.

[89] *Id.* at 335.

[90] *Id.* at 346–47 (citing *In re* Lifschutz, 467 P.2d 557, 561–62 (Cal. 1970) (en banc)). In *Lifschutz*, the court considered a claim by a psychiatrist refusing to testify and produce medical records of a former patient in a civil action brought by the patient claiming psychological injuries as a result of the defendant's alleged assault. 467 P.2d at 559. The former patient had not asserted privilege against disclosure and the court noted that having filed an action claiming damages for these injuries, he had effectively waived the privilege. The psychiatrist was held in contempt for failing to comply, asserting an absolute privilege in patient records as essential for therapy arguably based on constitutional grounds. *Id.* at 562. The court rejected this theory. *Id.*

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The majority referred to the recognition of a general evidentiary privilege for confidential communications made in the course of psychotherapy[91] and the exception to the general rule "[i]f the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."[92]

The majority then addressed the potential conflict between the goal of confidentiality in promoting patient disclosures of sources of personal anxiety when communicating with a therapist and the imposition of a duty to rely on those same disclosures. This includes the disclosure of the patient's actual communications as a basis for acting to protect third persons from violence that might be committed by dangerous patients. It explained:

> We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger.[93]

The *Tarasoff* majority thus addressed the concerns of Justice Clark's dissent by recognizing the continuing need to respect the general duty to maintain confidentiality in the psychotherapist/patient relationship. But it found that on the specific facts presented, the general obligation for confidentiality must give way to the protection of third persons from violence likely to be committed by dangerous patients. The need to balance confidentiality and the safety interests of potential victims of patient violence remains an important factor in determining both how a mental health professional's duty should be assessed in specific factual settings and when patient violence could likely give rise to liability when the dangerous patient injures, or kills, a third person not included in the special relationship that exists

[91] 551 P.2d at 346–47 (citing CAL. EVID. CODE § 1024 (West 2020)). As amended the code provisions now are §§ 1012, 1015.

[92] CAL. EVID. CODE § 1024 (West 2020). *See also* CAL. EVID. CODE § 1018 (West 2020) (discussing the confidentiality privilege when patient threatens to commit crime or tort).

[93] 551 P.2d at 347.

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between a patient, and their family members in some cases, and the patient's therapist.

For the therapist, the appropriate protocol for determining when the potential for patient violence warrants action on the mental health professional's part is critically important. This protocol is summarized by Professor Bruce Cohen in his psychiatry text:

> [C]linicians should keep in mind that the obligation to potential victims is to *take precautions to protect them, not simply warn them*. Therefore, when a patient has a history of violent behavior, or when the patient expresses current desires to harm others, the clinician is not automatically obligated to begin warning every person with whom the patient might have any contact. Rather, the clinician should *perform a risk assessment for violence* . . . . Warning the victim should be thought of as *one option for helping to minimize the risk of harm*. Other potential options include the following: increasing the *frequency of sessions*; *adjusting medications* to decrease psychotic symptoms; involving the *patient's family* in therapy; involving the *potential victim* in therapy (although the goals in such cases need to be carefully weighed against the risks); increasing the extent of *social supports* (e.g., the Department of Social Services, a substance rehabilitation program, Alcoholics Anonymous, outreach mental health programs for noncompliant patients); *voluntary hospitalization*; and *involuntary hospitalization*.[94]

The litany of professionally acceptable options for addressing expressions of violent tendencies by potentially dangerous patients suggests nothing less than the difficult decisions individual mental health professionals may need to consider in light of any particular factual scenario. The options available, as detailed by Professor Cohen, also may serve to complicate the determination about a professional's exercise of their independent judgment in seeking the best treatment situation for the patient, which may also cast any reasonable, but unsuccessful, therapeutic option actually selected by the treating professional susceptible to a retrospective finding of breach of professional duty. All of this illustrates the uncertainties that may compromise the work of psychotherapists in pursuing successful treatment for their patients, whose very actions in seeking or being ordered to therapy indicate their difficulty in adjusting to the normal requirements of peaceful life in the communities in which they reside.

[94] COHEN, *supra* note 82, at 464. Professor Bruce Cohen, M.D., is Associate Professor of Psychiatry and Neurobehavioral Sciences at the University of Virginia.

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B. The Issue Raised by the Therapist's Duty of Confidentiality

Justice Clark's concern for violation of the clinician's duty to maintain patient confidentiality in his *Tarasoff* dissent has been consistent with professional concerns over the decision's imposition of a duty to warn or protect third persons from dangerous patients. That concern has not been limited to the mental health professions but has been shared by the courts and legislators after *Tarasoff*. Significantly, *Tarasoff* recognized the duty in the context of civil litigation, in which the question of liability of treating mental health professionals based on alleged violations of confidentiality obligation arose.

There is no question that the confidentiality duty includes action taken by a mental health professional to protect a third person, or persons, from threats of violence articulated by the patient. The significance of the patient's expectation that disclosures made in the course of evaluation and therapy will remain confidential has not been disregarded; rather, it is the balancing of confidentiality and duty to others that has presented problems. With respect to the action of dangerous patients in committing acts of mass violence, it would seem logical that no informed medical or legal professional would dispute a citizen's belief that prevention of an act of mass violence warrants compromise of the therapeutic relationship.

In the aftermath of *Tarasoff*, two distinct responses have proved significant. First, the legislative response has focused primarily on the recognition of either mandatory or permissive duties to warn or protect potential victims of patient violence, resulting in statutory schemes designed to address patient violence by directing professionals in breaching confidentiality when necessary. These statutes often complement provisions that generally mandate confidentiality for mental health professionals. Second, jurisdictions have recognized that confidentiality may properly be protected by the adoption of evidentiary rules of privilege that protect patient disclosures made in the context of therapy from forced disclosure in litigation, with exceptions. Further, protection of confidentiality beyond the scope of evidentiary rules may be found in statutory provisions that recognize the duty of professionals not to disclose confidential disclosures by their patients, much as ethical rules set forth parameters for restriction of disclosures by clients to legal counsel.[95]

[95] *See* MARY ALICE FISHER, THE ETHICS OF CONDITIONAL CONFIDENTIALITY: A PRACTICE MODEL FOR MENTAL HEALTH PROFESSIONALS 220 (2013). Dr. Fisher reports:

> Some privileged communications statutes are very protective of patient confidentiality. Thirteen states have privilege statutes that are explicitly

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1. Confidentiality and the Therapeutic Relationship

The burden imposed upon mental health providers having a duty to warn potential victims of patient violence is not a matter simply discharged by effective risk assessment. It also necessarily suggests that the mental evaluation be conducted in light of the patient's likely need for continuing treatment to address the underlying causes of the impairment that may give the patient a propensity for violent action injuring third persons.

At the core of the professional relationship between mental health providers and their patients is the fiduciary duty owed to the patient by the therapist to protect the confidential disclosures made by patients during the course of therapy. The significance of the confidentiality duty is reflected in evidentiary rules treating disclosures made by patients in the course of therapy as privileged, although the duty may be recognized beyond the context of litigation, as it is in the Arizona statute governing the duty to maintain client confidences:

> The confidential relations and communication between a client or patient and a psychologist licensed pursuant to this chapter, including temporary licensees, are placed on the same basis as those provided by law between an attorney and client. Unless the client or patient waives the psychologist-client privilege in writing or in court testimony, a psychologist shall not voluntarily or involuntarily divulge information that is received by reason of the confidential nature of the psychologist's practice. The psychologist shall divulge to the board information it requires in connection with any investigation, public hearing or other proceeding. The psychologist-client privilege does not extend to cases in which the psychologist has a duty to report information as required by law.[96]

> modeled after attorney-client privilege, which is very protective unless there are extensive exceptions to that privilege within the statute or elsewhere. (See statutes for Alabama, Arizona, Arkansas, Georgia, Idaho, Kansas, Montana, New Hampshire, New Jersey, New York, Pennsylvania, Tennessee, Washington.)

Id.

[96] ARIZ. REV. STAT. § 32-2085 (2020). *See also*, *e.g.*, ARK. CODE ANN. § 17-97-105 (West 2020) (placing licensed psychologists and clients on the same basis as attorneys and clients); 740 ILL. COMP. STAT. 110/9 (2020) (authorizing disclosure of communications only as necessary to meet specific goals of statute); N.Y. C.P.L.R. LAW § 4508(a) (McKinney 2020) (extending confidentiality duty to licensed master social workers and licensed clinical social workers); UTAH CODE ANN. § 58-60-114 (West 2020) (permitting disclosure pursuant to statutory duty to warn, § 58-60-114(2)(b)(iii)).

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The Arizona statute phrases the confidentiality duty for psychologists in language strictly comparing that duty of an attorney to maintain confidentiality for client communications. Similar language is used in statutes of other jurisdictions.[97]

Similarly, the duty of the psychotherapist to maintain confidentiality with respect to patient disclosures in the course of therapy is also seen in the common judicial recognition of evidentiary privilege, protecting patient confidentiality in the course of litigation. In *Jaffee v. Redmond*,[98] the Supreme Court recognized the need for an evidentiary privilege that would protect the psychotherapist/patient relationship by insulating confidential information learned during that relationship from compelled disclosure in legal proceedings. Justice Stevens wrote for the majority:

> Like the spousal and attorney-client privileges, the psychotherapist-patient privilege is "rooted in the imperative need for confidence and trust." Treatment by a physician for physical ailments can often proceed successfully on the basis of a physical examination, objective information supplied by the patient, and the results of diagnostic tests. *Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace.* For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.[99]

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[97] For example, the Arkansas statute governing confidentiality for psychologists provides;

> For the purpose of this chapter, the confidential relations and communications between a licensed psychologist or a psychological examiner and a client are placed upon the same basis as those provided by law between an attorney and a client. Nothing in this chapter shall be construed to require any such privileged communication to be disclosed.

ARK. CODE ANN. § 17-97-105 (West 2020).

[98] 518 U.S. 1 (1996).

[99] *Id.* at 10 (emphasis added) (internal citations omitted). The majority noted that the Judicial Conference Advisory Committee had recommended adoption of an evidentiary privilege to protect confidential disclosures made to a psychotherapist by a patient during the course of treatment more than twenty years earlier, explaining: "[T]there is wide agreement that confidentiality is a *sine qua non* for successful

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The Court's decision in *Jaffee v. Redmond* resulted in recognition of an evidentiary privilege for psychotherapist/patient communications pursuant to the authority of federal courts under Evidence Rule 501.[100] In reaching this conclusion, the majority noted "[t]hat it is appropriate for the federal courts to recognize a psychotherapist privilege under Rule 501 is confirmed by the fact that *all 50 States and the District of Columbia have enacted into law some form of psychotherapist privilege*."[101] The Court mentioned the sources of protection for patient confidentiality in both legislation and by judicial decision, observing, "[i]t is of no consequence that recognition of the privilege in the vast majority of States is the product of legislative action rather than judicial decision. Although common-law rulings may once have been the primary source of new developments in federal privilege law, that is no longer the case."[102]

Not only does the federal evidentiary privilege preclude disclosures by psychiatrists and psychologists, but the *Jaffee* Court also recognized the need to extend the privilege, based on the confidentiality obligation, to other professionals

psychiatric treatment." *Id.* at 10–11 (citing Rules of Evidence for United States Courts and Magistrates Rules, 56 F.R.D. 183, 242 (1972) (Advisory Committee Note)).

[100] The Federal Rule of Evidence dealing with privileges in general provides:

> The common law—as interpreted by United States courts in the light of reason and experience—governs a claim of privilege unless any of the following provides otherwise:
> - the United States Constitution;
> - a federal statute; or
> - rules prescribed by the Supreme Court.
>
> But in a civil case, state law governs privilege regarding a claim or defense for which state law supplies the rule of decision.

FED. R. EVID. 501.

[101] 518 U.S. at 12 (emphasis added). The reasoning of the *Jaffee* majority was anticipated by the Arkansas Supreme Court in *State v. Sypault*, 800 S.W.2d 402 (Ark. 1990), where the court addressed questions relating to invocation of Rule 503 to prevent disclosure of confidential communications made during the course of therapy, explaining that "[t]he policy behind the physician and psychotherapist-patient privilege is to encourage patients to communicate openly with their physicians and therapists and to prevent disclosure of the patient's infirmities." *Id.* at 404. The *Sypault* Court referred to the privilege as one "that has been *firmly entrenched in Arkansas law since 1889*." *Id.* (emphasis added).

[102] 518 U.S. at 13.

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involved in mental health therapy.[103] It specifically addressed the need to recognize the counseling role performed by social workers.[104]

With respect to the duty to warn, however, the general obligation imposed upon mental health professionals to maintain the confidentiality of patient disclosures gives way to the obligation to protect third persons from prospective patient violence. The right that is found in recognition of an evidentiary privilege is not coextensive with a general duty to treat such disclosures as confidential, based on the therapeutic relationship between provider and patient. The evidentiary rule governs disclosure in the course of litigation; while it may reflect a general policy favoring non-disclosure, the evidentiary privilege is enforceable only through exclusion of evidence in official proceedings or in protecting the patient in circumstances attendant to litigation, such as depositions or discovery proceedings.

The recognition of confidentiality in the adoption of evidentiary privilege rules, whether the product of judicial or legislative action, does not preclude liability for practitioners who fail to warn or take appropriate action to protect third persons from dangerous patients, however. Civil liability for failure to protect third persons from violent acts committed by patients is a matter of policy within individual jurisdictions.

The concern for patient confidentiality as a key component in the therapeutic relationship led the Illinois Supreme Court to reject liability for practitioners for failure to warn or protect third persons from patient violence in *Tedrick v. Community Resource Center, Inc.*[105] The case involved allegations that the patient's therapist failed to warn the patient's wife of his threats toward her prior to her murder.[106] The court conducted a review of prior Illinois decisions that had fairly consistently held that third persons could not recover for injuries caused by patients based on claims of liability against their treating therapists.[107] It then rested its

[103] *Id.* at 15.

[104] *Id.* at 15–18; *see also*, *e.g.*, KY. REV. STAT R. EVID. 506(a)–(b) (2020) (defining "counselor" and privilege for patient communications).

[105] 920 N.E.2d 220 (Ill. 2009).

[106] *Id.* at 221.

[107] *Id.* at 224–25 (citing Kirk v. Michael Reese Hosp. & Med. Ctr., 513 N.E.2d 387, 398–99 (1987) (recovery against physician claimed strictly liable by third party passenger injured in automobile accident caused when discharged patient under influence of prescribed psychiatric medication and alcohol recovery not available under state law where plaintiff claimed physician did not warn patient of effects of medication, but no special relationship existed between physician and passenger); Doe v. McKay, 700 N.E.2d 1018, 1022 (Ill. 1998) (denying recovery based on father's claim that psychologist's negligence

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continuing adherence to the preclusion of recovery for claimed therapist negligence causing injuries to third persons by their patients based on the strong public policy interests favoring protection of the confidential relationship between mental health professionals and their patients.[108]

Tedrick and other decisions[109] illustrate a seeming internal inconsistency that may limit reliance on *Tarasoff* for third persons injured by violent patients. While a jurisdiction may impose a duty on the mental health professional to warn a dangerous patient's potential victim, the failure of the therapist to warn or take other measures to protect the victim will not necessarily give rise to a cause of action for the third person who is injured. In fact, however, there are quite different public policy considerations that would support even an inconsistent approach to the issues of duty and liability for mental health professionals addressing concerns regarding potentially dangerous patients. In balancing the critical interests involved in protecting patient confidentiality as a key element for successful therapy against the need to encourage mental health professionals to take action to protect third persons, the moderating factor relied upon may well not be promoting liability as a

caused daughter to erroneously believe father had sexually molested her as a child, injuring father/daughter relationship where no relationship existed between father and therapist with respect to this specific allegation)). In *Kirk*, moreover, there was no allegation that the treating physician was aware of any threat to the safety of the passenger, or allegation that the discharged patient was known to have violent propensities. 513 N.E.2d 387. The claim was grounded in strict liability, rather than negligence, in an apparent effort to address the lack of evidence of the physician's malpractice or actual negligence. *Id.* at 394.

[108] 920 N.E.2d at 224. The court referred to its earlier decisions in *Kirk* and *Doe* explaining: "[T]he problem of divided loyalties and the concerns about compromising patient confidentiality, 'argue strongly against imposing on therapists a duty of care toward nonpatients.'" *Id.* (citing *Doe*, 700 N.E.2d at 1024–25).

[109] *See, e.g.*, Chatman v. Millis, 517 S.W.2d 504, 506 (Ark. 1975) (privity doctrine precludes recovery against mental health professional for damages inflicted by patient where injured party not a patient of the professional because the therapist only owes a duty to their patient). Similarly, in reviewing a *Tarasoff* claim for psychiatrist's failure to warn unidentified third person killed by patient, Judge Harrison, in a concurring opinion in *Fleming v. Vest*, 475 S.W.3d 576, 582–83 (Ark. Ct. App. 2015), rejected the plaintiff's theory of recovery for medical malpractice, arguing that the cause of action sounded in negligence and did not arise under the Arkansas Medical Malpractice Act, ARK. CODE ANN. § 16-114-201 (2020). *Id.* at 582, 586. None of the three judges on the court of appeals panel addressed the need to reconsider the viability of *Chatman* and the application of the privity doctrine in malpractice cases, although the majority rested their reasoning on the application of the malpractice act on its broad language: "'Action for medical injury' means all actions against a medical care provider, whether based in tort, contract, or otherwise, to recover damages on account of medical injury as defined in this section[.]" *Fleming*, 475 S.W.3d at 580; ARK. CODE ANN. § 16-114-201(1) (2020).

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consequence of patient violence, but immunity for those professionals reasonably acting in good faith in attempting to balance the two concerns.

2. Confidentiality and Conflicting Public Policy Concerns

The balance between respect for patient confidentiality and the desirability of preventing injury to third persons by dangerous patients likely favors the protection of innocent persons over the need for confidentiality as an important, if not necessary, element in the therapeutic relationship. This approach is perhaps most clearly reflected in legislative action designed to protect children from maltreatment by requiring reporting of incidents of abuse or suspicion of abuse by those whose relationships with children represent the most obvious means by preventing further abuse through mandatory reporting.[110]

State[111] and federal[112] statutes typically identify those persons engaged in professional activities involving children as "mandatory reporters" having an affirmative duty to report suspected child abuse to appropriate agencies that

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[110] *See* FISHER, *supra* note 95, at 222–24. Professor Fisher states:

> All states have laws and/or regulations mandating the reporting of suspected child abuse or neglect, and most states also mandate the reporting of suspected abuse or neglect of elderly and/or vulnerable and/or incapacitated adults. These laws can be found in the state civil code or criminal code, or both . . . . All such laws include mental health care providers in the list of mandated reporters and include definitions of the person/conditions which must be reported. The wording of the reporting mandate varies; however, therapists are never required to investigate first, but instead are to report if they have "reason to suspect" or "reasonable cause to suspect" the abuse/neglect.

Id. at 222.

[111] *See, e.g.*, VT. STAT. ANN. 33, § 4913(c) (2020) requires mandatory reporter, as defined in subsection (a), "who reasonably suspects abuse or neglect of a child shall report in accordance with the provisions of section 4914 of this title within 24 hours of the time information regarding the suspected abuse or neglect was first received or observed." In sharp contrast, under Texas law, the reporting duty is extended beyond identified mandatory reporters to any person "having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person *shall* immediately make a report as provided by this subchapter." TEX. FAM. CODE § 261.101(a) (West 2020) (emphasis added).

[112] *See, e.g.*, 42 U.S.C. § 20341 (Supp. II 2020) (requiring a mandatory reporter, as defined under the statute, who "learns of facts that give reason to suspect that a child has suffered an incident of child abuse, shall as soon as possible make a report of the suspected abuse to" an appropriate agency, as identified in the statute. Medical professionals are designated as mandatory reporters under subsection (b)(1), while subsection (b)(2) includes as mandatory reporters "psychologists, psychiatrists, and mental health professionals.").

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investigate incidents of abuse.[113] The statutes reflect a strong public policy promoting the protection of children by imposing the statutory duty to report, facilitating investigation that may lead to the criminal prosecution of offenders.

The criminal charge in the Arkansas decision, *State v. Sypult*,[114] implicated this important public policy by requiring mandatory reporters to report suspected child abuse to the Arkansas intake agency, the Child Abuse Hotline, for investigation of reports of suspected abuse.[115] The applicable statute required that evidentiary privileges, other than the attorney-client privilege and later the clergy-penitent privilege, that would otherwise preclude disclosure of statements made in confidence must give way to the important policy of protecting children from abuse, and thus, such statements can be admitted at trial.[116]

The *Sypult* decision clearly tilts the policy balance in favor of the protection of children and does so by potentially penalizing the prospective patient's decision to seek professional treatment. The reporting duty imposed by the statute essentially transforms the patient disclosing misconduct involving a child into a perpetrator, at least for purposes of investigation of the report by the appropriate agency.[117] *Sypult* makes the proposed patient's decision to seek treatment relevant and admissible evidence in the criminal trial. The courts' determination of the admissibility of that decision and the subsequent report of the treatment to appropriate legal authorities imposes a significant burden on a patient who does seek treatment. It means that while their specific statements made in the course of diagnosis and treatment are excluded as privileged under Rule 503, the very act of seeking help from the mental health professional is subject to disclosure, which may be used as powerful evidence for the prosecution in the criminal proceeding.

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[113] *See* CHILD WELFARE INFORMATION GATEWAY, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 3, 5–68 (2019), https://www.childwelfare.gov/pubPDFs/manda.pdf.

[114] 800 S.W.2d 402 (Ark. 1990) (noting court's recognition of confidentiality privilege as long-standing feature of Arkansas law).

[115] The statute requiring reporting of suspected child abuse at issue in *Sypult* was ARK. CODE ANN. § 12-12-511, *repealed by* Acts of 2009, Act 749, § 2 (effective July 31, 2009). Under the current law, individuals identified as "mandatory reporters" are required to report suspected abuse supported by reasonable cause to the statutorily established Arkansas Child Abuse Hotline. ARK. CODE ANN. §§ 12-18-301; 12-18-402 (2020).

[116] ARK. CODE. ANN. §§ 12-18-402(b)(29)(A), (b)(41)(c)(1) (2020).

[117] Under Arkansas law, individuals making reports mandated by the statute are shielded from subsequent litigation brought by individuals who have been reported, as long as the reporter has acted in good faith. Cundiff v. Crider, 792 S.W.2d 604 (Ark. 1990).

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The determination that an individual's decision to seek treatment by a mental health professional for conduct may be subject to prosecution itself necessarily would serve to frustrate the proposed patient's expectation that treatment is available without the prospect of criminal prosecution. Because offenses relating to the abuse of children are viewed as extremely serious in criminal law, the mere fact of seeking treatment implicitly suggests conviction and imprisonment. Ironically, incarceration will almost certainly compromise any attempt to obtain treatment for the perceived impairment that prompted the search for professional help.

Ultimately, the *Sypult* Court's expressed recognition of the significance of confidentiality in the therapeutic relationship may actually prove to be rather hollow to patients for alternative reasons. It may well be that professional treatment really does not address the underlying motivation for assaults on children, particularly sexual assaults. Moreover, it may be that prospective patients seeking treatment for offenses they have committed are using the treatment option cynically in an effort to avoid prosecution, develop a defense to prosecution, or mitigate punishment without true acceptance of responsibility for their antisocial behavior. The effect of the court's holding, whether or not intended, may be to use the promise of the evidentiary privilege, protecting a patient's confidential disclosures, to induce offenders to seek treatment that will necessarily lead to their identification as a result of the mandatory reporting duty imposed on mental health professionals. Or, it may actually be that the meaning of *Sypult* is that protection of child victims is paramount, and the law itself cynically, but perhaps unintentionally, uses the promise of evidentiary privilege to induce perpetrators to disclose misconduct leading to the identification punishment of an offender through the mandatory reporting process imposed upon mental health professionals.[118]

III. THE RESPONSE TO *TARASOFF* FROM THE MENTAL HEALTH PROFESSIONS AND THE COURTS

Tarasoff resulted in the development of two independent lines of response from the judicial and legislative constituencies most affected by its reasoning. First, the decision directly influenced the understanding of the scope of duty imposed upon mental health professionals dealing with dangerous patients who articulate threats of violence directed at third persons or pose threats of violence within the context of

[118] ARK. CODE ANN. § 12-18-402(b) identifies the following individuals as mandatory reporters, among others: "[a] licensed nurse"; ["[m]edical personnel] who may be engaged in the admission, examination, care, or treatment of persons"; "[a] mental health professional or paraprofessional"; "[a] physician"; and "[a] social worker."

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their expressions of hostility without making direct threats.[119] For the mental health professionals treating dangerous patients, *Tarasoff* underscored the need to take appropriate action not only to warn or protect potential victims of patient violence but also the need to make professional decisions with an eye toward exposure to civil liability for failure to act.

Second, *Tarasoff* signaled the need, or opportunity, for legislative bodies to address the problem of patient violence by mandating or permitting disclosures for mental health professionals, regardless of whether civil liability or immunity would result from the discharge of the obligation to warn or protect. Professor Mark A. Rothstein notes the prevalence of legislative action responding to *Tarasoff*:

> In reviewing the state statutes, it is clear there is no single *Tarasoff duty*, but 51 jurisdiction-specific duties. As of 2014, 29 states have laws mandating the reporting of serious threats, 16 states and the District of Columbia have permissive reporting laws, four states have no duty to report, and one state (Georgia) has its own unique law.
>
> Some state statutes apply different standards to different professionals (e.g., psychologists, social workers). Other state laws differ on the circumstances when warnings or other actions are appropriate or vary in the individuals or entities that must be protected. Finally, some states grant immunity from liability if the mental health professional complies with certain statutory requirements.[120]

Thus, in examining the legacy of *Tarasoff*, or legacies, it is important to note that the recognition of a duty to warn or protect has led in two distinct directions that do not necessarily overlap unless a jurisdiction has also imposed civil liability for failure to comply with a legislative recognition of the mental health professional's duty to warn.

The California Supreme Court's decision became a touchstone for subsequent consideration of the duty of the mental health profession to warn potential victims of patient threats of violence. The ramifications of the holding spread throughout the

[119] Peter F. Lake, *Revisiting* Tarasoff, 58 ALB. L. REV. 97, 98 (1994) ("*Tarasoff* is the *Palsgraf* [Palsgraf v. Long Island R.R., 162 N.E. 99 (N.Y. 1928)] of its generation, a case with meta-significance which endures beyond its jurisdiction, time, place, and perhaps its particular holding.").

[120] Rothstein, *supra* note 68, at 104, 106 nn.23–30 (citing *Mental Health Professionals' Duty to Warn*, NAT'L. CONF. STATE LEGISLATURES (Oct. 12, 2018), http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx).

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legal system, with other courts, state[121] and federal,[122] considering claims brought against mental health providers based on violent acts committed by dangerous patients. The *Tarasoff* legacy has been extended to the highly authoritative statement of tort law by the American Law Institute in both its second and third editions of the *Restatement of Torts*, including, in Section 41 of the *Restatement (Third)*:

> (a) An actor in a special relationship with another owes a duty of reasonable care to third parties with regard to risks posed by the other that arise within the scope of the relationship.
> (b) Special relationships giving rise to the duty provided in Subsection (a) include: . . .
> (4) a mental-health professional with patients.[123]

Tarasoff has resulted in significant commentary by both mental health professionals and lawyers,[124] as well as widespread legislative action.[125] For instance, Harvard professor Alan A. Stone wrote in the almost immediate aftermath

[121] *See, e.g.*, Thapar v. Zezulka, 994 S.W.2d 635, 638–39 (Tex. 1999) (holding no cause of action for breach of duty to warn in light of TEX. HEALTH & SAFETY CODE § 611.002 (West 1999) creating statutory duty to maintain patient confidentiality and rejecting *Tarasoff* in refusing to create new cause of action).

[122] *See, e.g.*, Brady v. Hopper, M.D., 570 F. Supp. 1333, 1339 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984) (finding no breach of duty to warn by psychiatrist based on his treatment of patient John Hinkley's action in attempting to assassinate President Ronald Reagan, which occurred in context of shooting in which Presidential Aide James Brady was severely wounded, finding no foreseeable risk of injury).

[123] RESTATEMENT (THIRD) OF TORTS § 41 (AM. LAW INST. 2012). *See* Kuligoski v. Brattleboro Retreat & Ne. Kingdom Human Servs., 156 A.3d 436, 444–45 (Vt. 2016) (noting language of Section 41 of RESTATEMENT (THIRD) OF TORTS predecessor provisions in RESTATEMENT (SECOND) OF TORTS.

[124] *See, e.g.*, Paul S. Appelbaum, Tarasoff *and the clinician: Problems in Fulfilling the Duty to Protect*, 142 AM. J. PSYCH. 425–29 (1985); Lake, *supra* note 119, at 98; Christopher A. Tumminia & Marshall A. Glen, *The Duty to Warn in Oklahoma: A Survey of Law Across Licensed or Certified Psychotherapists*, 38 OKLA. CITY U. L. REV. 81, 91–101 (2013) (examining and comparing statutes providing for duty to warn for differing groups of regulated mental health professionals under state law); Rothstein, *supra* note 68; J. Thomas Sullivan, *Arkansas, Meet* Tarasoff*: The Question of Expanded Liability to Third Persons for Mental Health Professionals*, 69 ARK. L. REV. 987 (2017) (analyzing liability in light of traditional privity requirement for professional liability); William F. Doverspike, *The So-Called Duty to Warn: Protecting the Public Versus Protecting the Patient*, 61 GEORGIA PSYCH. 20 (2007), https://www.gapsychology.org/page/188 (discussing precedent in Georgia recognizing duty to protect third person against patient violence in *Bradley Center, Inc v. Wessner et al.*, 296 S.E.2d 693 (Ga. 1982), but arguing state courts have not recognized duty to "warn").

[125] *See* Rothstein, *supra* note 68.

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of the issuance of the *Tarasoff* rehearing opinion criticizing the adoption of a duty to warn or take other action to protect prospective victims of dangerous patient violence instead of relying on the involuntary civil commitment process as the preferable response in those situations.[126] He argued that the move toward alternatives to civil commitment represented an unwise rejection of that formal process, reflecting greater concern for patient liberty and protection of patient confidences than public safety:

> [T]he duty which the *Tarasoff* court imposes will reduce rather than increase public safety because it will diminish the ability and motivation of therapists to treat effectively mentally disturbed and potentially dangerous people. Public safety may nonetheless be served, and the moral duty of the therapist fulfilled, in more traditional ways: the therapist who believes that his patient poses a serious danger to third parties should attempt to have that person committed or, if that fails, should call the police when he is convinced that such action will protect both the victim and his patient. That has been the traditional moral and prudential view, and I believe it is still valid.[127]

Involuntary civil commitment remains an important option for addressing patient dangerousness and threats of violence, but strained resources for mental health care may compromise the ability of public mental healthcare facilities to provide an adequate response in immediate or longer-term contexts.[128] Fiscal and logistical constraints may typically lead to greater reliance on the criminal justice system—

[126] Alan A. Stone, *The* Tarasoff *Decisions: Suing Psychiatrists to Safeguard Society*, 90 HARV. L. REV. 358 (1976). Professor Stone is Touroff-Glueck Professor Emeritus of Law and Psychiatry at Harvard, holding a medical degree from Yale, and has served as President of the American Psychiatric Association. *Alan A. Stone*, HARVARD LAW SCHOOL: FACULTY PROFILES, http://hls.harvard.edu/faculty/directory/10853/Stone (last visited Nov. 9, 2020). His essay was highly critical of John Fleming & Bruce Maximov's *The Patient or His Victim: The Therapist's Dilemma*, 62 CALIF. L. REV. 1025 (1974), published while *Tarasoff* was pending in the California appellate courts and which Professor Stone argued influenced the reasoning of the California Supreme Court. Stone, *supra* note 126, at 361–62. The article was cited with approval by the *Tarasoff* majority. Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 352 (Cal. 1976), *on rehearing en banc*, 529 P.2d 553 (Cal. 1974). John M. Fleming, Professor Emeritus of Law at the University of California, Boalt Hall School of Law, who died in 1997, was the author of an influential treatise, *The Law of Torts* (1957), now in its 10th edition from Thomson-Reuters.

[127] Stone, *supra* note 126, at 373–74.

[128] NRI, TRACKING THE HISTORY OF STATE PSYCHIATRIC HOSPITAL CLOSURES, 1997–2015, at 1 (2015), https://www.nri-inc.org/media/1111/2015-tracking-the-history-of-state-psychiatric-hospital-closures-lutterman.pdf ("Since the 1950s, the number of beds in state psychiatric hospitals has declined by over 91 percent.").

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jails and prisons—as institutional destinations for patients evidencing dangerous attitudes and behavior.[129]

Despite criticism from informed observers like Professor Stone, *Tarasoff* has profoundly impacted the development of the law relating to the duty of mental health professions to warn or take other measures to protect third persons from patient violence over the past forty years. Perhaps most significantly, the duty of mental health professionals to warn third persons of patient dangerousness has consistently been the subject of study by professional organizations most directly involved in advising those professionals with respect to their obligations, such as the American Academy of Psychiatry and the Law,[130] the American Psychological Association,[131]

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[129] *See* H. Richard Lamb & Linda E. Weinberger, *The Shift of Psychiatric Inpatient Care From Hospitals to Jails and Prisons*, 33 J. AM. ACAD. PSYCHOL. & L. 529 (2005), https://pdfs.semanticscholar.org/7347/b6e62abbbce5dcc657aa74868f856d5670a6.pdf. Dr. Lamb is Professor of Psychiatry and Director, Division of Psychiatry, Law, and Public Policy, and Dr. Weinberger is Professor of Clinical Psychiatry and Chief Psychologist, Institute of Psychiatry, Law, and Behavioral Sciences, Keck School of Medicine, University of Southern California, Los Angeles, California. The authors observe:

> Over the past few decades in the United States, there has been a profound paradigm or model shift in the care of persons with severe mental illness. For many, their psychiatric inpatient care is now provided in jails and prisons. This, in large part, may be the result of structural changes that have been made in the mental health system—namely, a radical reduction in long-term, intermediate, and short-term psychiatric inpatient treatment under mental health's jurisdiction. Moreover, few in the mental health field discuss the need for inpatient treatment, despite evidence that some persons with severe mental illness cannot be effectively treated and/or managed in the community and require 24-hour structured care.

Id.

[130] *See, e.g.*, Alan R. Felthous, *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?*, 34 J. AM. ACAD. PSYCHOL. & L. 338 (2006), http://jaapl.org/content/34/3/338 (national survey of judicial decisions involving state approaches to *Tarasoff* duty); Rebecca Johnson, Govind Persad & Dominic Sisti, *The* Tarasoff *Rule: The Implication of Interstate Variation and Gaps of Professional Training*, 42 J. AM. ACAD. PSYCHOL. & L. 469 (2014) (evaluating efficacy of duties imposed on mental health professionals to warn intended victims of potential violence by patients and noting flaws in warning protocol based on lack of national and professional uniformity in approach); Kristen Lambert & Moira Wertheimer, *What is My Duty to Warn?*, PSYCHIATRIC NEWS (Jan. 11, 2016), http://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2016.1b1; Matthew F. Soulier, Andrea Maislen & James C. Beck, *Status of the Psychiatric Duty to Protect, Circa 2006*, 38 J. AM. ACAD. PSYCHIATRY L. 457 (2010) (observing that most post-*Tarasoff* litigation has resulted in verdicts favoring clinicians).

[131] *See, e.g.*, Stephen Behnke, *Disclosing Confidential Information*, 45 AM. PSYCHOL. ASS'N 44 (2014), http://www.apa.org/monitor/2014/04/disclosing-information.aspx (The author, director of the APA's Ethics Office, discusses the duty to warn imposed by statute in Massachusetts pursuant to Massachusetts General Laws, chapter 123, section 36B, including his explanation that statute does not require warning where warning itself could contribute to escalation of dangerousness into violence and also discusses the

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and the National Association of Social Workers.[132] National attention to the development of a duty to warn or protect third persons from dangerous patients is also reflected in other sources of collected information. For instance, the National Conference of State Legislatures has collected data relating to state legislative action tracking developments in *Tarasoff*-based statutory duties, providing a detailed fifty-state summary of statutes that mandate warnings or other protective measures; that permit confidentiality to be breached by issuing a warning or pursuing other protective measures; or that prohibit breaches of confidentiality for the purpose of issuing warnings.[133]

For mental health professionals, *Tarasoff* threatened a substantial change in therapeutic protocol because it created a heightened expectation for therapists to accurately assess the risk of whether a patient's threats would be manifested in actual acts of violence. But the adoption and application of standards incorporating the most significant aspects of the *Tarasoff* approach to liability have not been limited to judicial interpretation; *Tarasoff* has also triggered a substantial and varied legislative response that poses a significant concern for mental health professionals placed in the position of evaluating legal duties in light of their professional judgments.

Dr. Alan R. Felthous, Professor and Director of Forensic Psychiatry at St. Louis University School of Medicine, offered a comprehensive review of *Tarasoff*-based litigation and legislation in his article in the *Journal of the American Academy of Psychiatry and the Law* in September 2006.[134] Professor Felthous analyzed the

duty of psychologists to report child abuse.); Yvona L. Pabian, Elizabeth Welfel & Ronald S. Beebe, *Psychologists' Knowledge of Their States' Laws Pertaining to* Tarasoff-*Type Situations*, 40 PROF. PSYCHOL. 8 (2009), http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2009-01453-012 (reporting study showing general lack of understanding with respect to reporting duties under state law); Damon Muir Walcott, Pat Cerundolo & James C. Beck, *Current Analysis of the* Tarasoff *Duty: An Evolution Towards the Limitation of the Duty to Protect*, 19 BEHAV. SCI. L. 19, 325–43 (2001), http://onlinelibrary.wiley.com/doi/10.1002/bsl.444/full; s*ee also* Michael R. Quattrocchi & Robert F. Schopp, *Tarasaurus Rex: A Standard of Care That Could Not Adapt*, 11 PSYCHOL. PUB. POL'Y L. 109 (2005), http://dx.doi.org/10.1037/1076-8971.11.1.109 (criticizing "lay" responses dictated by *Tarasoff* in light of professional norms).

[132] *See, e.g.*, Elizabeth Gaskill, *Duty to Warn*, NAT'L ASS'N SOC. WORKERS, MASS. CHAPTER (Nov. 1996), http://www.naswma.org/?116 (discussing duty to warn under Massachusetts statute); Stephen Granich, *Duty to Warn; Duty to Protect*, NEW SOC. WORKER, Winter 2012, at 4 (hypothetical ethical problems faced by social workers).

[133] *See Mental Health Professionals' Duty to Warn*, *supra* note 120; GRIFFIN SIMS EDWARDS, DATABASE OF STATE *TARASOFF* LAWS (Feb. 11, 2010), https://dx.doi.org/10.2139/ssrn.1551505.

[134] *See* Felthous, *supra* note 130.

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complexity of the scope of duty imposed in light of the treatment of the duty by courts and the subsequent legislative action in advising mental health professionals of the circumstances under which the need to take specific action arises.[135] He posited that the duty could be viewed from both the clinician's perspective, in which the duty is "driven primarily by the clinician's duty to warn of a recognized danger," or from the perspective of a victim, in which their interest is in being "warned based on a concern-arousing event."[136]

The legacy of *Tarasoff* is complicated by inconsistency in judicial applications that may focus too sympathetically on the injury sustained by a third party and too unsympathetically on the reality of the therapeutic relationship. Professor Felthous explains:

> Warning practices vary over a spectrum ranging from those that are essentially legally required duties of clinicians to those based on rights of actual or potential victims to be warned. These warning practices can be categorized as following: (1) warning of the risk of violence after the clinician appraised the risk to be serious and probable; (2) warning of the threat of violated based only the threat itself; (3) requested warning, based on a potential victim's perceived risk of threat to self; and (4) required criminal victim warning mandated by statute when requested by a person who had already been criminally victimized by the offender in question. In contrast to the first three practices, warnings to individuals who have already been criminally victimized do not involve participation of mental health professionals.[137]

Professor Felthous cautions that while *Tarasoff* may be taken to mean that the therapist issues a warning to an intended victim when a specific threat has been made, in fact, the duty to warn is based upon an assessment that the victim is subject to "danger" for which warning is the "appropriate protective measure."[138] He points to an early post-*Tarasoff* decision, *McIntosh v. Milano*,[139] in which the New Jersey

[135] *Id.*

[136] *Id.* at 338.

[137] *Id.* at 338–39.

[138] *Id.* at 340. The author explained: "According to the *Tarasoff* principle, the intended victim is to be warned of the 'danger'. . . posed by the patient, not simply of the patient's verbal threat." *Id.* at 340; *see also* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 340 (Cal. 1976), *on rehearing en banc*, 529 P.2d 553 (Cal. 1974).

[139] 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979).

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Superior Court denied summary judgment sought by the therapist on a claim of liability to a third party injured by the patient. The court found that breach of duty to warn or protect was consistent with state law[140] but noted that post-*Tarasoff* legal commentary reflected substantial doubt concerning the ability of therapists to be able to make reasonably accurate conclusions about which patients presented an actual likelihood of acting upon hostile thoughts in committing violent acts.[141]

At roughly this same point in time, the issue of the ability of mental health professionals to predict "future dangerousness" was a critically important, emerging issue in criminal justice contexts, largely attributable to the finding of "future dangerousness" as the key issue in capital punishment decisions rendered by Texas juries in death penalty trials. In *Barefoot v. Estelle*,[142] the Supreme Court upheld the United States Court of Appeals for the Fifth Circuit's denial of a stay of execution in rejecting Barefoot's attack on the prosecution's use of forensic expert's opinion responding to a hypothetical question regarding the *probability* that he would commit acts of criminal violence in the future if sentenced to life imprisonment.[143] The Court upheld both the denial of the stay and the circuit court's rejection of Barefoot's argument that the expert testimony could not be based on hypothetical questions but required an in-person examination.[144] The Court had previously upheld the use of forensic opinion evidence on the issue of "future dangerousness" of convicted capital defendants in *Estelle v. Smith*,[145] noting approval of the statutory scheme adopted in Texas to require capital juries to consider whether the imposition of a death sentence would be warranted as part of the sentencing process.[146]

The problem posed by risk assessment is critical for the determination of whether a breach of the standard of care has resulted from a therapist's failure to warn or take other protective action, of course, because the imposition of a duty to

[140] *Id.* at 509, 511–12.

[141] *Id.* at 505 n.8.

[142] 463 U.S. 880, *aff'g* 697 F.2d 593 (5th Cir. 1983).

[143] *Id.* at 902–03.

[144] *Id.* at 896–98.

[145] 451 U.S. 454, 472 (1981).

[146] *Id.* (discussing Jurek v. Texas, 428 U.S. 262 (1976)). In *Jurek*, the Court construed TEX. CODE OF CRIM. PROC. ANN. art. 37.071 (West 1975–76) as constitutional under the Eighth Amendment, which includes a special issue for juror determination regarding "whether there is a probability that the defendant would commit criminal acts of violence that would constitute a continuing threat to society." 428 U.S. at 269.

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act is theoretically dependent upon whether the mental health professional can be expected to correctly assess patient threat or propensity for violence. It may be the case that on any given set of facts, no therapist could be expected to make a determination sufficiently accurate to reasonably impose a duty to take protective measures. Moreover, even if the risk assessment does point toward action, another problem lies in determining exactly what corrective measure would be necessary or appropriate under the circumstances.

Focusing on California decisions in his analysis, Professor Felthous references the factually troubling case of *Jablonski, by Pauls, v. United States*.[147] There, the trial court found that the treating Veterans Administration (VA) psychiatrists had a duty to warn the homicide victim, Melinda Kimball, of the patient's potential for violence directed toward women based on his attempted rape of her mother, Isobel Pahls.[148] When the VA doctor warned Ms. Kimball that Philip Jablonski presented a threat to Kimball, with whom he lived, she rejected his suggestion that she leave Jablonski, explaining, "I love him." The psychiatrist did not warn her further because "she would not listen to him."[149]

The United States Court of Appeals for the Ninth Circuit concluded that the psychiatrist failed to take sufficient action to warn Kimball of the perceived threat, deferring to the finding of the trial court. It also deferred to the trial court's finding that the VA therapists were negligent in failing to access and review Phillip Jablonski's medical history in assessing the violence risk, a finding contested by the Government on the basis of the evidentiary record, holding that the finding was not clearly erroneous.[150]

The court's conclusions reflect the sort of problems that may arise in a post-*Tarasoff* action. Here, the VA psychiatrists apparently made a correct professional judgment in assessing the risk posed by Phillip Jablonski and they also correctly anticipated that Melinda Kimball was in the scope of danger, even though the

[147] Felthous, *supra* note 130, at 340. *See* 712 F.2d 391 (9th Cir. 1983) (adopting de novo review of interpretation of state law, rather than deferring to district court's interpretation unless clearly erroneous in diversity action). Isobel Pahls, Meghan Jablonski's grandmother, brought the wrongful death action as guardian for her granddaughter.

[148] 712 F.2d at 393. While the Circuit Court included considerable discussion of statutory immunity in its analysis, it addressed the single issue of the liability of the Veterans Administration hospital in resolving the plaintiff's outstanding claim. *Id.* at 397 ("Only the liability of the hospital is presented to us in this appeal.").

[149] *Id.*

[150] *Id.* at 398–99.

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decision includes no reference to any specific threat directed at her personally. Jablonski had, however, attacked Kimball's mother, Isobel Pauls, and attempted to rape her. During a significant history following the incident in which he attacked Pauls, Jablonski, accompanied by Kimball, sought diagnosis and treatment at the VA hospital. It ultimately proved unsuccessful when Jablonski murdered Kimball.[151] Liability was based on the wrongful death action brought by Kimball's daughter, Meghan, based on Jablonski's murder of her mother. The VA psychiatrist had warned Kimball of the danger he perceived but was rebuffed by her response to his suggestion that she leave him. Moreover, the record showed that Kimball had, herself, disclosed her fear of Jablonski.[152]

One might well question exactly what more the defendants could have been expected to do in terms of warning Kimball that she was in danger. Nevertheless, the Ninth Circuit found a breach of his duty, perhaps resting its finding of negligence on the fact that she was eventually murdered.[153]

There were additional facts warranting immediate action or the involuntary hospitalization of Jablonski. These facts included Jablonski's prior conviction and five-year prison sentence for raping his wife; the incident involving Pahls four days prior to his interview at the VA; and the fact that the investigating officer had disclosed his record and recommendation that Jablonski be treated as an in-patient to the head of psychiatric services at the VA, who failed to relate this information to the psychiatrist evaluating Jablonski.[154] Jablonski had also been treated for schizophrenia in a military hospital with documented threats to his wife.[155] The

[151] *Id.* at 393–94.

[152] In contrast to the disposition in *Jablonski*, the Iowa court in *Estate of Votteler*, declined to apply *Tarasoff* in holding that the psychiatrist was not liable for a third person's injuries inflicted by his patient when the third person herself was fully aware of the patient's violent disposition and previous threats to kill her. 327 N.W.2d 759, 761–62 (Iowa 1982); *accord* Cantrell v. United States, 735 F. Supp. 6670 (E.D.N.C. 1988); Boulanger v. Pol, 900 P.2d 823, 835–36 (Kan. 1995) (stating there is no liability when victim already aware of threat); Cairl v. State, 323 N.W.2d 20 (Minn. 1982).

[153] Professor Cohen explains that assessment of the therapist's lack of warning about a potentially dangerous patient's facts "can be exacerbated by 'hindsight bias' by a plaintiff's expert, since it is always easier for a somebody *retrospectively* reviewing a patient's chart (i.e., after the patient has killed or seriously injured another person) to recognize how 'obvious it should have been' that a particular patient was dangerous. In actuality, things aren't as clear *prospectively*." COHEN, *supra* note 82, at 463.

[154] 712 F.2d at 397 ("The district court's primary findings of malpractice concerned a failure to record and communicate the warning by the police, the failure to secure Jablonski's prior records, and the failure to warn Kimball.").

[155] The *Jablonski* court noted:

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treating psychiatrist testified that, had he had this information, he would have pursued involuntary hospitalization after Jablonski refused to voluntarily commit himself.[156] Despite the consistent opinion that he was dangerous, the VA psychiatrists concluded that he did not present a case for involuntary hospitalization and directed Jablonski to return for a follow-up appointment the following Monday, three days later. Jablonski killed Kimball that Sunday.[157]

The decision suggests that the duty on the part of the mental health professional is not fulfilled simply by a timely warning directed to an identified, or reasonably identifiable, victim. Instead, the duty may be breached when the therapist's warning proves insufficient and the evidence warrants further action, such as emergency, involuntary hospitalization. But in the case of Jablonski, the therapist likely could not have known what additional action would have been required; instead, the therapist only learned that the warning failed once Kimball was murdered. Even though the entire body of evidence relating to the patient's history of violence and diagnosis presents a compelling argument for finding a breach of the standard of care, from the therapist's perspective, the Ninth Circuit's analysis would almost certainly lead to a conclusion that it is simply too difficult to understand what precisely the duty encompasses in terms of protecting the injured third person, given Kimball's expressed refusal to leave Jablonski when advised to do so.

Two additional questions that might be asked concern the procedural history of the case in the trial process. First, the wrongful death suit was brought pursuant to the Federal Tort Claims Act[158] against the United States, rather than against one or more of the individual psychiatrists who could have been named and theoretically held personally liable in a private action. Had the three doctors named in the court's opinion been sued personally, rather than identified as staff of the Veterans

> The El Paso records reported that Jablonski had a "homicidal ideation toward his wife," that on numerous occasions he had tried to kill her, that he "had probably suffered a psychotic break and the possibility of future violent behavior was a distinct probability," and that he was "demonstrating some masculine identification in beating his wife as his father did frequently to his mother." The final diagnosis concluded in part that Jablonski had a "schizophrenic reaction, undifferentiated type, chronic, moderate; manifested by homicidal behavior toward his wife."

Id. at 393–94.

[156] *Id.* at 393.

[157] *Id.* at 394.

[158] 28 U.S.C. §§ 1346(b); 2671–80 (2018).

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Administration hospital where Jablonski was seen shortly before the murder, the trial court might have been inclined to consider the defense's comparative negligence claim, based on Kimball's refusal to heed the warning to leave Jablonski. Second, one might consider the effect of the case being tried by a judge rather than a jury, which might have been far more skeptical of Kimball's behavior despite her admitted fear of Jablonski in assessing the liability of the psychiatrists who warned her of his dangerousness.[159]

Much of the mental health community's opposition to *Tarasoff* liability is based on questioning the assumption that therapists are actually able to assess, with a reasonable degree of medical certainty, when hostility and anger will escalate into acts of violence against intended or unknown victims. Professor Cohen noted that the American Psychiatric Association (APA) "strongly disagreed" with *Tarasoff*, in part because of the difficulty in predicting violent behavior, noting: "Since most patients don't go on to commit serious violence, clinicians would be forced to make many unnecessary warnings [based on the *Tarasoff* rationale], violating confidentiality in each of these cases."[160]

For instance, the APA's amicus brief in *Barefoot v. Estelle*[161] argued against prosecutors' reliance on long-term violence predictions rendered by psychiatrists in Texas capital sentencing proceedings. While conceding that short-term predictions are far more reliable than long-term predictions of dangerousness,[162] the APA argued that the latter are more reliably based on factors that are unrelated to mental illness, such as prior history of criminal behavior, sex, age, race, substance or alcohol abuse, and history of chronic unemployment, all statistical facts that could be presented through lay witnesses without the unintended effect of clothing testimony witness credibility with undeserved emphasis on psychiatric expertise.[163]

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[159] 712 F.2d at 393 ("In a private conference following the diagnostic interview, Kimball told Kopiloff that she felt insecure around Jablonski and was concerned about his unusual behavior. Kopiloff recommended that she leave Jablonski at least while he was being evaluated. When Kimball responded 'I love him,' Kopiloff did not warn her further because he believed she would not listen to him."). Even after Kimball moved out of Jablonski's apartment and in with her mother, "Kimball continued to see Jablonski, however, and drove him to the hospital for his second appointment." *Id.* at 394.

[160] *See* COHEN, *supra* note 82, at 463.

[161] Brief for the American Psychiatric Association as Amicus Curiae Supporting Petitioner at 4–8, Barefoot v. Estelle, 463 U.S. 880 (1983) (No. 82-6080).

[162] *Id.* at 4 n.7.

[163] *Id.* at 5–6.

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The APA's position in *Barefoot* presented a viable argument against reliance on forensic prediction of the probability of a capital defendant committing acts of criminal violence in the future, relevant in the context of the sentencing proceeding in which imposition of a death sentence is being considered by the jury. But, its argument also provides support for the imposition of a duty to respond to immediate threats or evidence of violent, dangerous predisposition on the part of a patient.[164] In differentiating between the accepted ability of mental health professionals to make judgments as to the likelihood of patient violence in the near-term, the APA explained:

> Predictions of short-term future behavior are to be distinguished from predictions of long-term future dangerousness in this regard. In civil commitment cases, for example, as this Court recognized in *Addington v. Texas*, 441 U.S. 418 (1979), psychiatrists are commonly called on to make predictions about short-term prognoses, and such predictions sometimes include potential violence. *The psychiatrist is able to evaluate the patient's current mental condition and to discern its likely effect on behavioral patterns, including potentially violent behavior in the near future.* Such situations, however, are clinically different from predictions of long-term dangerousness because they are made in the context of specific and usually acute mental illnesses (for example, severe depression), and they are made with knowledge of the individual's short-run environmental situation, which may have a direct bearing on the likelihood that he will act dangerously.[165]

What the APA's position in *Barefoot* shows for purposes of *Tarasoff* liability is that regardless of the professional discomfort over the imposition of duties to warn or take other protective action, even the APA acknowledges that mental health professionals, undoubtedly with varying degrees of proficiency, can make reasonably accurate assessments of risk with respect to potential patient violence in appropriate situations.[166] Those factors that enhance accuracy may themselves vary, but almost always will start within the patient-therapist relationship, the exception likely being a controlled situation in which patients are subject to observation by professionals not actively engaged in therapy at the time.

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[164] *Id.* at 4 n.6.

[165] *Id.* at 4 n.7 (emphasis added).

[166] *Id.*

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Despite the widespread influence of *Tarasoff* on other courts, its reasoning has been resisted in some jurisdictions, such as Texas, where the state supreme court refused to impose civil liability on a psychiatrist based on failure to warn claim in *Thapar v. Zezulka*.[167] The Texas Supreme Court did not engage in analysis of the comparative values of confidentiality and prevention of injury, unlike the *Tarasoff* court. The case involved Dr. Thapar's treatment of Freddy Ray Lilly over a three-year period after her initial diagnosis of the patient's "moderate to severe post-traumatic stress disorder, alcohol abuse, and paranoid and delusional beliefs concerning his stepfather, Henry Zezulka, and people of certain ethnic backgrounds."[168] Lilly disclosed his wish to kill Zezulka during a period of hospitalization, but Dr. Thapar concluded that he had decided not to kill his stepfather and discharged him. Within a month, Lilly shot and killed Zezulka.[169]

In reversing the intermediate appellate court,[170] the Texas Supreme Court reinstated the summary judgment granted to Dr. Thapar on the ground that Texas law did not recognize a cause of action based on the duty of a mental health professional to warn a third person of a patient's disclosed threat to commit an act of violence toward the third person.[171] It relied on continuing recognition of the privity requirement to preclude an action for professional negligence or malpractice.[172] Since the therapist did not have a professional relationship with the victim's wife, she owed no duty to her based on a failure to correctly diagnose Lilly's danger to his stepfather.[173] Thus, the theory of Dr. Thapar's liability was inconsistent with Texas precedent limiting professional liability to circumstances in which the physician-patient relationship would govern the mental health professional's duty arising directly from that relationship.

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[167] 994 S.W.2d 635 (Tex. 1999).

[168] *Id.* at 636.

[169] *Id.*

[170] Zezulka v. Thapar, 961 S.W.2d 506, 511–12 (Tex. App. 1997).

[171] *Thapar*, 994 S.W.2d at 640.

[172] *Id.* ("Because of the Legislature's stated policy, we decline to impose a common law duty on mental-health professionals to warn third parties of their patient's threats. Accordingly, we conclude that Thapar was entitled to summary judgment because she owed no duty to Zezulka, a third-party nonpatient."). The legislative policy referenced by the court is found in TEX. HEALTH & SAFETY CODE § 611.002 (West 1996).

[173] *Id.* at 638.

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The court of appeals had essentially held that the gravamen of the complaint was not the misdiagnosis—a claim for medical malpractice—but rather the failure to warn the victim,[174] referencing *Tarasoff* and noting other Texas decisions in which *Tarasoff* had been discussed in the warning context.[175] The supreme court initially rejected this distinction, holding that because Zezulka's complaint was grounded in the misdiagnosis of Lilly, the therapist had not violated a duty arising from diagnosis because Zezulka was not her patient.[176]

The Texas Supreme Court then considered the conclusion of the intermediate court that Dr. Thapar owed a duty to Zezulka to convey Lilly's threat to kill him, predicated on a common law theory of duty not based upon professional negligence, distinguishing these two theories of liability.[177] It explained:

> We are not faced here with the question of whether a doctor owes a duty to third parties to warn a patient of risks from treatment which may endanger third parties.[13] Instead, we are asked whether a mental-health professional owes a duty to directly warn third parties of a patient's threats.[178]

The supreme court did not adopt *Tarasoff*'s approach to the traditional recognition of a duty at common law to protect individuals within the scope of foreseeability of injury.[179] There was no apparent consideration of the importance of confidentiality in maintaining a therapeutic relationship based upon trust but focused instead on the potential liability of psychotherapists.

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[174] 961 S.W.2d at 511.

[175] *Id.* at 511 n.2.

[176] *Thapar*, 994 S.W.2d at 638. The court relied on Texas precedent, holding that a physician owes no duty to non-patients who ultimately is injured by the patient to correctly diagnose a patient, unless the physician provides a prescription. *Id.* (citing Gooden v. Tips, 651 S.W.2d 364, 365–66 (Tex. App. 1983) (Where the physician prescribed Quaalude, there was a duty to warn the patient not to drive that extended to third party later injured.); Flynn v. Houston Emergicare, Inc., 869 S.W.2d 403, 405–06 (Tex. App. 1994) (A doctor treating a patient for cocaine abuse had no duty to warn third person injured by patient while driving under influence of cocaine because the injury was not attributable to any impairment cause by physician's diagnosis.)).

[177] *Thapar*, 994 S.W.2d at 638–39.

[178] *Id.* at 638.

[179] *Id.* at 638 n.15. The court noted that the intermediate appellate court had relied on *Tarasoff* in finding Thapar potentially liable and cited prior decisions of Texas intermediate appellate courts discussing *Tarasoff*. *See Zezulka*, 961 S.W.2d at 511 n.2.

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Instead, it predicated its holding on the statutory protection afforded to patient confidentiality. In responding to the question, the court relied upon Texas law affirming the duty of the mental health professional to maintain the patient's confidence in disclosures made in the course of treatment or therapy.[180] The applicable statute[181] recognized a limited exception to the confidentiality duty:

> (a) A professional *may* disclose confidential information only: . . .
> (2) to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient . . . .[182]

Thus, the court concluded that the confidentiality statute did not *require* mental health professionals to disclose patient threats to prospective victims but only *permitted* the professional to disclose a threat to "medical or law enforcement personnel."[183]

The problem posed by this permissive warning approach recognized by the Texas Supreme Court under state law is that it affords little direction or protection to the mental health providers in addressing the potential consequences of patient threats of violence. The statute limits disclosure of threats to medical or law enforcement personnel but does not include an identified victim of the threat. This limits liability in actions brought by victims or their families when the threatened action is actualized and results in injury or death, and this provides significant protection for the therapist. However, because no specific duty to warn or protect is included in the statute, arguably, the therapist is placed in the position of assessing whether the "patient or others" might be injured by the patient's actions consistent with a disclosed threat.[184]

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[180] *Thapar*, 994 S.W.2d at 639.

[181] TEX. HEALTH & SAFETY CODE § 611.004(a)(2).

[182] *Id.* The court noted the original language found in § 4, 1979 TEX. GEN. LAWS 514, was consistent with the language included in the HEALTH AND SAFETY CODE. 994 S.W.2d at 639.

[183] *Id.* at 639 ("The statute, however, *permits* these disclosures but does not *require* them . . . .").

[184] HEALTH & SAFETY § 611.004(a)(2).

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Moreover, the therapist would be exposed to potential liability for any warning or other protective action in the event the assessment of the seriousness of the patient's threat was incorrect, as the court explained:

> [T]he statute does not shield mental-health professionals from civil liability for disclosing threats in good faith. On the contrary, *mental-health professionals make disclosures at their peril*. Thus, if a common-law duty to warn is imposed, mental-health professionals face a Catch-22. They either disclose a confidential communication that later proves to be an idle threat and incur liability to the patient, or they fail to disclose a confidential communication that later proves to be a truthful threat and incur liability to the victim and the victim's family.[185]

Thus, the therapist could be held accountable for violating the confidentiality duty imposed under the statute, even if the therapist has acted in good faith. The statute simply offers no immunity when the warning or protective act is the result of diagnostic error or overreaction on the therapist's part.

This *permissive* approach, which neither imposes a statutory duty to warn or protect nor affords immunity when the therapist acts in good faith, subjects the therapist to potential liability for acting based on a moral duty to attempt to prevent violence or injury to a patient's intended victim. It reflects a rejection of *Tarasoff*, creating something of a default position for therapists to decline action when confronted by uncertainty with respect to the dangerous patient's willingness or ability to actually act, and favors inaction even when dangerousness is likely certain to result in violence or injuries to others. The Texas position remains a minority view with respect to the duty imposed upon mental health professionals, however.

IV. THE LEGISLATIVE RESPONSES TO *TARASOFF*

> *Most states have laws that either require or permit mental health professionals to disclose information about patients who may become violent. Those laws are receiving increased attention following recent mass shootings, such as those in Aurora, Colo., and Newtown, Conn.*
> *A New York law enacted Jan. 15, 2013, moves that state's law from a permissive to a mandatory duty for mental health professionals to report when they believe patients may pose a danger to themselves or others but protects therapists from both civil and criminal liability for failure to report if they act "in good faith."*

[185] *Thapar*, 994 S.W.2d at 640 (emphasis added).

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New York's new law also allows law enforcement to remove firearms owned by patients reported to be likely to be dangerous.[186]

A. Statutory Schemes Authorizing Seizure of Weapons, or "Red Flag" Laws

Less than two weeks after the most deadly mass shooting in Canadian history, Prime Minister Justin Trudeau announced that possession of "military-grade assault" weapons was immediately banned in the country, including some 1,500 models and makes of these weapons.[187] The ban resulted from the fatal shootings of at least twenty-three people over April 18–19, 2020, with the Prime Minister explaining, "[t]hese weapons were designed for one purpose and one purpose only: to kill the largest number of people in the shortest amount of time. There is no use and no place for such weapons in Canada."[188]

There has been no comparable rapid response to mass violence leading to significant restrictions on ownership of similar weapons in the United States, attributable in significant part to the Supreme Court's selective incorporation of the Second Amendment right to bear arms in *McDonald v. City of Chicago*.[189]

The perceived or demonstrated links between mental illness or other impairment and mass violence, however, has prompted legislative responses that

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[186] *See Mental Health Professionals' Duty to Warn*, *supra* note 120; McIntosh v. Milano, 403 A.2d 500, 505 n.8 (N.J. Super. Ct. Law Div. 1979).

[187] *See* Amanda Coletta, *Canada Announces Immediate Ban on 'Military-Grade' Assault Weapons*, WASH. POST (May 1, 2020), https://www.washingtonpost.com/world/the_americas/canada-bans-military-grade-assault-weapons/2020/05/01/1a5b524c-8bc4-11ea-80df-d24b35a568ae_story.html.

[188] *See* Ian Austen, *Canada Bans Assault Weapons in Wake of Deadly Mass Shooting*, N.Y. TIMES (May 1, 2020), https://www.nytimes.com/2020/05/01/world/canada/canada-bans-assault-weapons.html ("The ban means that Canadians will no longer be able to own rifles like the AR-15, the military-style weapon used in several mass shootings in the United States including those in Sandy Hook, Conn.; Orlando, Fla.; and Parkland, Fla."). On the same day as the announcement of the Canadian ban on military grade assault weapons, protesters, many armed with weapons similar to those banned in Canada, entered the Michigan state capitol to oppose Governor Gretchen Whitmer's continuing enforcement of the state's social distancing restrictions designed to combat the COVID-19 epidemic designated a national emergency by President Trump, while he tweeted support for the protesters. *See* Jason Slotkin, *Protesters Swarm Michigan Capitol Amid Showdown Over Governor's Emergency Powers*, NPR (May 1, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/05/01/849017021/protestors-swarm-michigan-capitol-amid-showdown-over-governors-emergency-powers.

[189] 561 U.S. 742, 759 (2010).

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may indirectly address the potential for mass murder.[190] These responses typically focus on restricting access to weapons, principally firearms, by mentally impaired individuals—"red flag laws" or "Extreme Risk Protection Orders."[191] These laws, which authorize seizure of firearms from potentially dangerous individuals by law enforcement,[192] contemplate statutory schemes that facilitate preemptive action by mental health professionals, to whom patients will often express interest in violent acts, or more specifically, in terms of threatened violence toward others.[193]

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[190] *See* Noel Brinkerhoff & Steve Straehley, *Two States Allow Seizing Guns from Mentally Ill; Other States on Hold*, ALLGOV (July 8, 2014), http://www.allgov.com/news/controversies/two-states-allow-seizing-guns-from-mentally-ill-other-states-on-hold-140708?news=853622. Other jurisdictions did eventually adopt so-called "red flag laws." *See* Nick Wing & Melissa Jeltsen, *Wave of 'Red Flag' Gun Laws Shows Power of the Parkland Effect*, HUFFINGTON POST (June 16, 2018), https://www.huffpost.com/entry/red-flag-laws-parkland-florida-massacre_n_5b24099fe4b056b22639d8cb (updated June 17, 2018). For a discussion of red flag laws particularly relevant to problems arising from possession of weapons by elderly individuals who may suffer from diminished mental capacity, see Tara Sklar, *Elderly Gun Ownership and the Wave of Red Flag Laws: An Unintended Consequence That Could Help Many*, 27 ELDER L.J. 35, 44–46 (2019) (table referencing state adoption of "red flag" laws permitting seizure of weapons from individuals suspected of being dangerous).

[191] *See, e.g.*, Redington v. State, 121 N.E.2d 1053, 1054 (Ind. Ct. App. 2019) ("'Red flag laws' generally allow law enforcement to seek a court order temporarily restricting a person's access to firearms if that person shows 'red flags' of being a threat of danger to themselves or others.").

[192] Sklar, *supra* note 190, at 40–43 (providing an overview of state adoption of *red flag laws* and "Extreme Risk Protection Orders," focusing particularly on the problems of gun access for the elderly, a segment of the population often most prone to suicide). The author describes these state laws:

> Red flag laws, also referred to as Extreme Risk Protection Orders ("ERPO"), allow law enforcement—and in eight states, family or household members—to file a petition for a court order to temporarily remove a person's access to guns when they show "red flags" by exhibiting dangerous behavior.[7] These laws are often referenced in the media and by legislators as a response to curb mass shootings, as evidenced by the number of states with red flag laws having doubled since the mass school shooting in Parkland, Florida on February 14, 2018.

Id. at 37. On the matter of the success of the Connecticut firearms seizure law, see Jeffrey W. Swanson, Michael A. Norko, Hsiu-Ju Lin, Kelly Alanis-Hirsch, Linda K. Frisman, Madelon V. Baranoski, Michele M. Easter, Allison G. Robertson, Marvin S. Swartz & Richard J. Bonnie, *Implementation and Effectiveness of Connecticut's Risk-Based Gun Removal Law: Does It Prevent Suicides?*, 80 LAW & CONTEMP. PROBS. 179 (2017) ("[E]nacting and implementing laws like Connecticut's civil risk warrant statute in other states could significantly mitigate the risk posed by that small proportion of legal gun owners who, at times, may pose a significant danger to themselves or others. Such laws could thus save many lives and prove to be an important piece in the complex puzzle of gun violence prevention in the United States.").

[193] The Supreme Court has historically recognized the legality of state laws providing for the involuntary hospitalization, or civil commitment of mentally disturbed individuals who have injured or threatened to

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Connecticut enacted legislation authorizing the seizure of weapons from dangerous individuals in 1999,[194] following a workplace mass shooting at the Connecticut state lottery committed by an employee.[195] The statute provides for the seizure of weapons,[196] based on a detailed list of acts supporting the issuance of a warrant, including:

> (1) Recent threats or acts of violence by such person directed toward other persons; (2) recent threats or acts of violence by such person directed toward himself or herself; and (3) recent acts of cruelty to animals as provided in subsection (b) of section 53-247 by such person. In evaluating whether such recent threats or acts of violence constitute probable cause to believe that such person poses a risk of imminent personal injury to himself or herself or to others, the judge may consider other factors including, but not limited to (A) the reckless use, display or brandishing of a firearm by such person, (B) a history of the use, attempted use or threatened use of physical force by such person against other persons, (C) prior involuntary confinement of such person in a hospital for persons with psychiatric disabilities, and (D) the illegal use of controlled substances or abuse of alcohol by such person.[197]

injure others or themselves. *See, e.g.*, Addington v. Texas, 441 U.S. 418, 426 (1979) ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill."); Zinermon v. Burch, 494 U.S. 113, 131 (1990) (confinement of mentally ill based on threat of violence demands protection from violation of due process rights); O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) ("A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom.").

[194] CONN. GEN. STAT. ANN. § 29-38c (West 2020).

[195] Jonathan Rabinovitz, *Rampage in Connecticut: The Overview; Connecticut Lottery Worker Kills 4, then Himself*, N.Y. TIMES (Mar. 7, 1998), https://www.nytimes.com/1998/03/07/nyregion/rampage-connecticut-overview-connecticut-lottery-worker-kills-4-bosses-then.html.

[196] CONN. GEN. STAT. ANN. § 29-38c(a) (West 2020).

[197] § 29-38c(b). One reported incident, however, demonstrates the flaw that undermines the prospects for achieving the goal of removing firearms from the mentally ill over the long-term, however. Michael Luo & Mike McIntire, *When the Right to Bear Arms Includes the Mentally Ill*, N.Y. TIMES (Dec. 21, 2013), http://www.nytimes.com/2013/12/22/us/when-the-right-to-bear-arms-includes-the-mentally-ill.html. The *New York Times* reported:

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The statutory scheme identifies situations in which potential use of firearms in mass shootings could be addressed by preemptive action by law enforcement and the courts. However, only section (C), which refers to "prior involuntary confinement" of the individual for "psychiatric disabilities," actually ties the seizure of weapons to mental illness, although the alternatives may indicate some propensity or possibility of violent use of the individual's weapons.

Section (C), which links the emergency seizure of weapons to the firearm owner's history of mental illness or behavior warranting involuntary civil commitment, builds on the general process for hospitalization of individuals whose behavior warrants temporary loss of liberty. Involuntary civil commitment for mental diagnosis or treatment is traditionally accepted as an option for authorities to deal with individuals whose impairments are manifested by acts or threats of violence against others or themselves.[198] Moreover, it is an option generally available for use by mental health professionals, law enforcement officers, or concerned individuals to prevent injury in emergency situations.[199] However, this involuntary

> Last April, workers at Middlesex Hospital in Connecticut called the police to report that a psychiatric patient named Mark Russo had threatened to shoot his mother if officers tried to take the 18 rifles and shotguns he kept at her house. Mr. Russo, who was off his medication for paranoid schizophrenia, also talked about the recent elementary school massacre in Newtown and told a nurse that he "could take a chair and kill you or bash your head in between the eyes," court records show.

Id. Following seizure of the patient's seven firearms, he began to take his medication once again and, under Connecticut law, was eligible to seek their return after one year. *Id.* He was quoted as saying: "I don't think they ever should have been taken out of my house," he said. "I plan to get all my guns and ammo and knives back in April." *Id.* The article references a number of instances in which mentally ill individuals, often suspects or others involved in confrontations with law enforcement, have engaged in acts of fatal gun violence.

[198] *See Addington*, 441 U.S. at 426 ("The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill."). Given the infringement on the involuntarily-committed patient's liberty interest, the *Addington* Court concluded that the State prove that the proposed patient suffers from a mental impairment and that the patient presents a threat to himself or others by "clear and convincing evidence"—the intermediate standard of proof for infringement on personal liberty interests between the reasonable doubt standard imposed for criminal convictions and the preponderance of evidence standards generally applicable in civil actions—in order to prevent unjust or unreasonable violations of individual liberty more likely if the preponderance standard is used. *Id.* at 432–33.

[199] *See, e.g.*, CONN. GEN. STAT. ANN. § 17a-502 (West 2020). The statute provides for involuntary commitment of any person who, in the opinion of a physician, "has psychiatric disabilities and is dangerous to himself or others or gravely disabled, and is in need of immediate care and treatment in a

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civil commitment process failed in *Tarasoff* when, despite the therapist's concern about Poddar's potential for violence, the officers did not take him into custody after questioning him.[200]

The Connecticut weapon seizure law, however, does not involve an acceptable infringement on an individual's liberty interest due to involuntary hospitalization based on evidence of violence or violent threats attributed to mental state. Instead, it raises an altogether different infringement, the loss of access to weapons, now constitutionally protected under the Second Amendment.[201] When confronted by a challenge to the weapon seizure law based on the guarantee of the right to bear arms in *Hope v. State*,[202] the Connecticut Court of Appeals rejected the challenge, relying on the Supreme Court's decision in *District of Columbia v. Heller*.[203] There, the Court explained that state legislatures could resort to statutory restrictions "to prevent the violence associated with firearms."[204] The state court concluded:

> Section 29–38c does not implicate the second amendment, as it does not restrict the right of law-abiding, responsible citizens to use arms in defense of their homes. It restricts for up to one year the rights of *only those whom a court has adjudged to pose a risk of imminent physical harm to themselves or others* after affording due process protection to challenge the seizure of the firearms.[205]

The parameters of the Second Amendment protection afforded individuals in possession of firearms have yet to be precisely defined by the Supreme Court with respect to seizure statutes—"*red flag laws*"—that permit state authorities to seize

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hospital for psychiatric disabilities, may be confined in such a hospital, either public or private, under an emergency certificate as hereinafter provided for not more than fifteen days. . . ." *Id.*

[200] Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 339–40 (Cal. 1976).

[201] McDonald v. City of Chicago, Ill., 561 U.S. 742, 750 (2010); District of Columbia v. Heller, 554 U.S. 570 (2008).

[202] 133 A.3d 519 (Conn. App. 2015).

[203] *Id.* at 524 (citing *Heller*, 554 U.S. at 626) (holding that the right to possess firearms is not absolute under the Second Amendment).

[204] *Heller*, 554 U.S. at 627 n.26, 636.

[205] *Hope*, 133 A.3d at 52425. The court noted that the California Court of Appeals had reached a similar conclusion in *City of San Diego v. Boggess*, 157 Cal. Rptr. 3d 644, 650–54 (2013), in holding that the California statute allowing state to seize firearms from persons detained for examination due to mental illness who are likely to cause a danger did not violate the Second Amendment.

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firearms based on a showing of an individual's history of cruelty to animals, mental illness, or abuse of alcohol.[206] Given the history of mass shootings and state efforts to prevent violence committed with firearms, it seems probable that this issue will eventually reach the Supreme Court for the purpose of express delineation of the protection afforded by the individual's constitutional "right to bear arms."[207]

A number of states have adopted "red flag laws" authorizing the seizure of firearms or other weapons from individuals suspected of having the potential for violence toward themselves or others[208] since the action initially undertaken by the Connecticut legislature.[209] States that have adopted this approach include Florida, with the state legislature acting[210] in the aftermath of the shooting at the high school in Parkland to adopt the popularly titled "Marjory Stoneman Douglas High School Public Safety Act."[211] The legislature explained the basis for its action:

> The Legislature finds there is a need to comprehensively address the crisis of gun violence, including but not limited to, gun violence on school campuses. The Legislature intends to address this crisis by providing law enforcement and the courts with the tools to enhance public safety *by temporarily restricting firearm possession by a person who is undergoing a mental health crisis and when there is evidence of a threat of violence*, and by promoting school safety and

[206] *See* CONN. GEN. STAT. § 29-38c(b) (2020) for evidentiary factors the court may consider in authorizing a seizure of the individual's firearms.

[207] U.S. CONST. amend. II ("A well regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.").

[208] *See, e.g.*, CAL. CIV. PROC. CODE § 527.9 (West 2012); COLO. REV. STAT. §§ 13–14.5–101 to –114 (2019); DEL. CODE ANN. tit. 11, § 1448C (West 2019); D.C. CODE §§ 7–2510.01–.12 (2019); FLA. STAT. § 790.401 (2018); 430 ILL. COMP. STAT. 67/1–67/80 (2019); MD. CODE ANN., PUB. SAFETY §§ 5–601 to –610 (West 2018); MASS. GEN. LAWS ch. 140, §§ 131R–131Y (2018); OR. REV. STAT. §§ 166.525–.543 (2018); 1956 R.I. GEN. LAWS § 8-8.3-1 (2018); WASH. REV. CODE ANN. § 7.94.030 (West 2020).

[209] *See, e.g.*, Redington v. State, 121 N.E.2d 1053, 1054 n.2 (Ind. Ct. App. 2019) ("Prior to February 2018, five states including Indiana had red flag laws. After the February 14, 2018, shooting at Marjory Stoneman Douglas High School in Parkland, Florida, at least eight other states and the District of Columbia have enacted a red flag law."). California adopted legislation permitting removal of firearms on petition of a family member who believes a relative poses a threat in response to the mass shooting killing six and wounding 13 others near the University of California at Santa Barbara before the shooter killed himself. Ryan J. Foley & Don Thompson, *Few States Let Courts Take Guns from People Deemed a Threat*, ASSOCIATED PRESS (Feb. 18, 2018), https://www.apnews.com/d1bcb2afb9e24df8bdacf3eacde95352.

[210] FLA. STAT. § 790.401 (2018).

[211] Davis v. Gilchrist Cty. Sheriff's Office, 280 So. 3d 524, 528 (Fla. Dist. Ct. App. 2019).

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> enhanced coordination between education and law enforcement entities at the state and local level.[212]

The statutory scheme expressly predicates the action to seize firearms on a showing that the individual suspected of threatening violence be "undergoing a mental health crisis," arguably requiring evaluation by a mental health professional.[213] However, the findings supporting an order for seizure of the individual's firearms do not include or even reference a finding by a mental health professional that the respondent is undergoing or has undergone "a mental health crisis."[214]

Over a decade earlier, Indiana enacted legislation in 2005[215] authorizing authorities to seize firearms under a warrant issued based upon a credible showing by police that an individual has demonstrated "dangerousness" resulting from mental illness, emotional instability, or propensity for violence.[216] With respect to the required showing of an individual's dangerousness, the statute provides:

> (a) For the purposes of this chapter, an individual is "dangerous" if:
> (1) the individual presents an imminent risk of personal injury to the individual or to another individual; or
> (2) It is probable that the individual will present a risk of personal injury to the individual or to another individual in the future and the individual:

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[212] *Id.* at 532 (emphasis added) (quoting 2018 FLA. LAWS 1-3).

[213] *Id.* There is no statutory requirement for the evaluation of the respondent by a mental health professional, however. In *Davis*, the trial court heard evidence from a neuropsychologist called by Davis who opined that his violent behavior was "probably relatively normal" in light of stress he was suffering at the time, but rejected this expert opinion worth "little weight." *Id.* at 529.

[214] FLA. STAT. § 790.401(3)(c).

[215] IND. CODE §§ 35-47-14-1 to 35-47-14-13 (2020). Indiana authorized seizure of guns from dangerous persons believed to suffer from mental impairment as a strategic response to the need to prevent gun violence in 2005. *See States Look to Gun Seizure Law After Mass Killings*, FOX NEWS, https://www.foxnews.com/politics/states-look-to-gun-seizure-law-after-mass-killings (last updated Dec. 20, 2015). But the existence of a "red flag law" does not assure that the public will be protected from the acts of a mass shooter, as the incident at the FedEx distribution center in Indianapolis on April 15, 2021 illustrates. *See infra* Part VII and Epilogue. Local law enforcement officials had previously arrested the perpetrator of the mass shooting and seized a shotgun, but failed to take necessary legal action under the Indiana "red flag" law to confiscate the weapon. The shooter subsequently purchased two semi-automatic weapons used the FedEx shooting.

[216] § 35-47-14-2. This section authorizes a court to issue a warrant for the seizure of "a firearm in the possession of an individual who is dangerous," once the court determines that "probable cause exists to believe that the individual is (A) dangerous; and (B) in possession of a firearm." *Id.* § 35-47-14-2 (a)(3).

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> (A) has a mental illness (as defined in IC 12-7-2-130) that may be controlled by medication, and has not demonstrated a pattern of voluntarily and consistently taking the individual's medication while not under supervision; or
>
> (B) is the subject of documented evidence that would give rise to a reasonable belief that the individual has a propensity for violent or suicidal conduct.[217]

Not only does the Indiana statute address the potential for violence attributable to a statutorily-defined "mental illness,"[218] it is sufficient to prove that the individual poses an imminent risk of injury to himself or another person. This alternative basis for relief disregards the mental state of the respondent but does not provide any basis for hospitalization based on impaired mental state, which would result in an infringement on the individual respondent's personal liberty interest in being free from confinement.[219]

State "red flag" laws that address dangerousness without requiring proof of impaired mental state are designed primarily to authorize action based on the need to protect others, or the respondent, from injury inflicted through the use of firearms, rather than any legislative intent to tie access to firearms to mental impairment.[220] Thus, the threat of injury, not treatment of mental illness or other impairment, is the focus of the legislation, while other statutory provisions serve to address the need for involuntary civil commitment to deal with the range of psychiatric problems that might precipitate injury to the impaired individual or other persons. In *Addington v. Texas*, the Court recognized the traditional process of involuntary civil commitment for hospitalization of a mentally disturbed individual threatening the safety of others, or himself.[221]

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[217] *See* § 35-47-14-1.

[218] § 35-47-14-2(a)(2)(A).

[219] Although, in appropriate circumstances, this infringement on personal liberty of the patient who is involuntarily hospitalized, is warranted based on the threat posed by the impaired individual who is shown to be a threat to others or himself.

[220] §§ 35-47-14-1(a)(1), (2)(A).

[221] 441 U.S. 418 (1979). The Court addressed the constitutionally-required burden of proof placed upon the State when seeking to civilly commit an individual for hospitalization for an "emotional disturbance," *id.* at 425, affirming:

> The state has a legitimate interest under its *parens patriae* powers in providing care to its citizens who are unable because of emotional disorders to care for

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The "red flag" law, permitting seizure of firearms without a required showing that the respondent suffers from an impaired mental state, represents an important middle ground in terms of providing options to authorities in an effort to prevent violence. This is likely particularly true in situations involving the potential for domestic violence in which interpersonal antagonism, rather than diagnosed mental impairment, represents the most likely reason for injury. These statutes permit law enforcement to take affirmative action to prevent violence, rather than forcing them to respond only after it has been reported and victims have been harmed by the violent actor. This may be especially important with respect to acts of domestic violence involving the use of firearms.

Federal constitutional protection of individual liberty interests effectively bars the State from using indefinite commitment of violent individuals to protect others, as the Supreme Court explained in *Foucha v. Louisiana*.[222] There, the Court rejected continuing confinement of an insanity acquittee once mental health professionals concluded that Foucha did not suffer from a mental state impairment warranting involuntary civil commitment or hospitalization necessary for treatment.[223] Instead, the state hospital staff sought to continue his commitment because of their conclusion that while not mentally ill, Foucha's violent nature posed a continuing threat of injury to others.[224] The Court held, however, that an insanity acquittee is "'entitled to release when he has recovered his sanity or is no longer dangerous,' *i.e.*, the acquittee may be held as long as he is both mentally ill and dangerous, but no longer."[225]

B. Legislation Addressing the Therapist's Duty to Protect or Warn

While legislation addressing the use of firearms in the commission of violent acts places the focus on the availability of weaponry to facilitate individual or mass

> themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill.

Id. at 426. The Court held that the standard of proof required for involuntary commitment is "clear and convincing evidence." *Id.* at 431–32.

[222] 504 U.S. 71 (1992).

[223] *Id.* at 74–75, 78, 80.

[224] *Id.* at 75–76.

[225] *Id.* at 77 (citing Jones v. United States, 463 U.S. 354, 368 (1983)) (holding that insanity acquittee may be confined upon acquittal for mental defect because the conviction establishes the acquittee's dangerousness and the insanity establishes the mental impairment warranting involuntary hospitalization without requirement of proof under *Addington*, 441 U.S. 418).

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shootings, the alternative approach focuses on addressing the impaired mental state of many individuals involved in targeted or random violence. State laws have long provided mental health professionals and others with the option of seeking immediate, emergency hospitalization by the civil commitment of those patients disclosing credible threats of intent to commit violent acts or who display symptoms of psychosis warranting intervention.

But state statutes are inconsistent in their focus on the action to be taken by the mental health professional confronting a dangerous patient, particularly when the patient has evidenced hostility or articulated general or specific threats, the latter which may involve identification of intended victims. When the identification of an intended victim is available to the therapist, the obligation for warning logically increases, based on *Tarasoff*'s reasoning.[226]

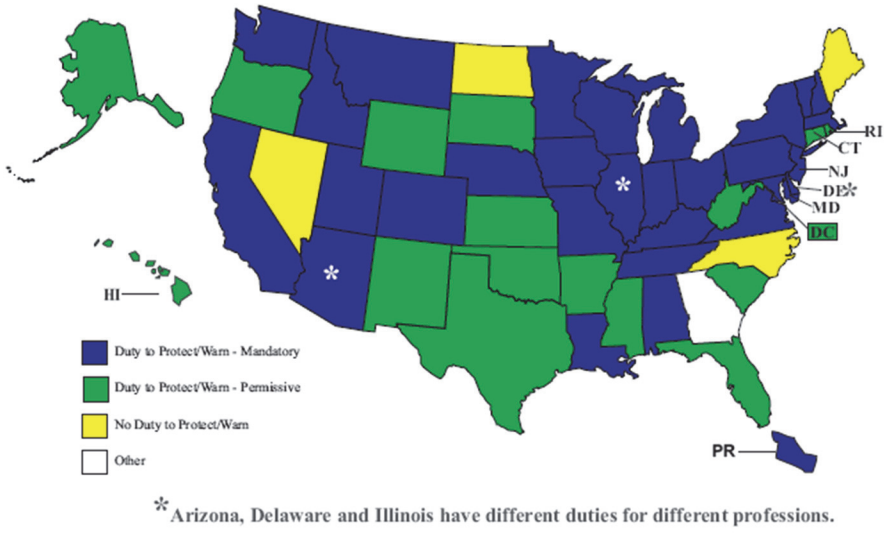

Figure 1. Mental Health Professionals' Duty to Protect/Warn

This 2018 survey by the National Conference of State Legislatures[227] of state laws governing the duty of mental health professionals to warn or take protective measures to prevent injury to third persons by dangerous patients illustrates the significant legislative response to the problem of patient violence, even in jurisdictions that have been less aggressive in terms of developing theories of civil

[226] The victim in *Tarasoff*, Tatiana, was readily "identifiable." Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 341, 345 n.11 (Cal. 1976) (noting that duty will vary depending upon facts of each case).

[227] *See Mental Health Professionals' Duty to Warn*, *supra* note 120; EDWARDS, *supra* note 133.

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liability arising from injuries sustained by third persons. The approaches taken by the states lack uniformity, but they have been categorized in one study as follows:

> In addressing this question, we can distinguish between three general categories of states: those that mandate some duty to warn or protect (and that often specify whether law enforcement, the victim, or a combination should be "warned"); those that allow therapists to warn by protecting them from liability for breach of confidentiality if they do so, but do not require them to issue a warning; and those that offer no statutory or case law guidance. We highlight the ethics-based and legal implications of this variation for health professionals.[228]

The authors then analyze the ways in which variation in statutory approaches impact the performance of professional duties in specific ways based on the respective legislative directives, concluding, in part:

> Interstate variation in the duty to warn or protect raises normative questions about how this variability may impede mental health professionals' knowledge of their duties. Inadequate knowledge not only exposes therapists to legal risks, but also may impede a therapist's ability to fulfill an identifiable victim's moral claim to be warned about or protected from substantial harm. When legal scholars have difficulty parsing the reasoning behind various *Tarasoff*-related rulings, it seems unreasonable to expect mental health care professionals and law enforcement officers to discharge these duties correctly without increased guidance and support.[229]

They also offer an interesting conclusion about the implications of *Tarasoff* in civil actions in their 2014 analysis: while *Tarasoff* generated significant concern and speculation that imposition of a duty to warn or protect against patient violence would threaten to "compromise the therapeutic relationship," jury verdicts tended to

[228] *See* Johnson et al., *supra* note 130, at 470.

[229] *Id.* at 476.

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favor therapists.[230] Jury verdicts favoring victims were the result of the most egregious violations of the standard of care.[231]

C. Variations in the Legislative Approach

Even a cursory review of a few state statutes imposing a duty on mental health professionals to respond to potential violence on the part of dangerous patients demonstrates considerable variation in the approaches taken both with respect to the factor triggering professional action and the action expected of the professional once evidence of this potential for violence arises.[232] Only four states are identified by the National Conference of State Legislatures as having no statutory regulation addressing warnings: Maine, North Carolina, North Dakota, and Nevada.[233]

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[230] *Id.* at 475. The authors noted:

> Whereas much of the early commentary surrounding *Tarasoff* consisted of dire proclamations about the damaging effect the rulings would have on psychotherapy, with commentators arguing that the therapeutic relationship would be irremediably compromised by the ensuing regulations, recent court cases illustrate that therapists are very rarely held liable. [A]n analysis of 70 appellate cases from 1985 to 2006, found that 46 were decided in favor of the mental health professional, 6 were decided in favor of the plaintiff (although only 4 of these used *Tarasoff* statutes), and 17 were returned to trial courts for further litigation. Mental health professionals were exonerated on the following bases: no imminent threat was communicated to a therapist about an identifiable victim; the victim was already aware of the danger; or the therapist warned the victim, but the victim took actions that went against the warning.
>
> Courts appeared to rule in favor of the victims only in marked cases of negligence by the mental health professional or institution.

Id. at 475 (citing Soulier et al., *supra* note 130).

[231] *Id.* at 475–76.

[232] *Id.* at 469.

[233] *Mental Health Professionals' Duty to Warn*, *supra* note 120 (map of states with respect to warning statutes).

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1. Mandatory Duty to Warn or Protect

a. Imposition of Duty by Statute: The New York Statute

Some state statutes, like New York's, expressly impose a duty on mental health professionals to take protective measures to ensure the safety of third persons from dangerous patients. Amended in 2013,[234] the statute provides:

> Notwithstanding any other law to the contrary, when a mental health professional currently providing treatment services to a person determines, in the exercise of reasonable professional judgment, that such person is likely to engage in conduct that would result in serious harm to self or others, he or she shall be required to report, as soon as practicable, to the director of community services, or the director's designee, who shall report to the division of criminal justice services whenever he or she agrees that the person is likely to engage in such conduct.[235]

The New York statute does not obligate the mental health professional to report a determination that the patient is dangerous to an identified victim, but rather to law enforcement. Nor does it rest on disclosure of a specific threat or disclosure of an intended victim by the patient, instead providing for a report of a generalized finding of dangerousness in the course of treatment.

b. Imposition of Duty and Immunity: The Colorado Statute

A common feature in many state statutes involves the creation or extension of statutory immunity for mental health providers in reporting patient threats or assessments of dangerousness. The Colorado statute[236] combines both a mandatory duty to report and immunity for reporting psychotherapists:

> (2)(a) A mental health provider is not liable for damages in any civil action for failure to warn or protect *a specific person or persons, including those identifiable by their association with a specific location or entity*, against the violent behavior of a person receiving treatment from the mental health provider, and any such mental health provider must not be held civilly liable for failure to predict such

[234] N.Y. MENTAL HYG. LAW § 9.46 (McKinney 2020).

[235] *Id.* § 9.46(b).

[236] COLO. REV. STAT. ANN. § 13-21-117 (West 2020).

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> violent behavior except *where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity*.[237]

Subsection (2)(a) provides statutory immunity for the mental health provider who reports potential patient violence by warning or taking other protective action, limiting the duty to identified or identifiable victims. Subsection (2)(b) then explains that the alternative protective action also includes notification of an "appropriate law enforcement agency" and may include involuntary, emergency hospitalization. But the provision also requires warnings to identified or identifiable victims, or those appropriate when a threat indicates a particular venue where violence may occur. The subsection then reiterates the general immunity protection afforded mental health professionals reporting potential patient violence. This compromise directive expressly provides:

> (b) When there is a duty to warn and protect under the provisions of paragraph (a) of this subsection (2), the mental health provider shall make reasonable and timely efforts to notify the person or persons, or the person or persons responsible for a specific location or entity, that is specifically threatened, as well as to notify an appropriate law enforcement agency or to take other appropriate action, including but not limited to hospitalizing the patient. A mental health provider is not liable for damages in any civil action for warning a specific person or persons, or a person or persons responsible for a specific location or entity, against or predicting the violent behavior of a person receiving treatment from the mental health provider.[238]

Significantly, in light of recent acts of mass violence that apparently involve random victims, the requirement of warning based on a particular "location or entity" where mass violence may be targeted, such as a school, workplace, or public venue, expands the duty beyond those formulations of the duty that focus only on identified or identifiable victims.

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[237] *Id.* § 13-21-117(2)(a) (emphasis added).

[238] *Id.* § 13-21-117(2)(b).

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c. Statutory Duty Based on Case Law: The California Scheme

The California statute governing the duty to protect prospective victims of patient violence,[239] § 43.92 of the Civil Code, addresses the duty in negative terms and predicates the discharge of the duty only when the patient has made "a serious threat of physical violence against a reasonably identifiable victim or victims" as expressly included in subsection (a):

> (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.
> (b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified in subdivision (a), discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.[240]

Rather than affirmatively defining the duty, the statute actually provides immunity from liability for monetary damages[241] when a psychotherapist makes an appropriate effort to protect a prospective victim[242] who is the subject of a patient's threat to

[239] CAL. CIV. CODE § 43.92 (West 2020).

[240] *Id.*

[241] Subsection (a), moreover, not only insulates mental health professionals taking appropriate action to protect third persons from injury, but also provides that there is no cause of action based upon the therapist's action. COLO. REV. STAT. ANN. § 13-21-117(2)(a). If an attempt to protect victims from injury fails because the effort was unsuccessful, perhaps even due to some negligence on the part of the protecting therapist, based on the language in subsection (b) referring to "reasonable efforts" to communicate the threat to either the intended victim or law enforcement, the mental health provider is not liable for damages. *Id.* § 13-21-117(2)(b). Other state statutes use immunity to stimulate warnings or other acts designed to protect potential victims. *See, e.g.*, ALA. CODE § 34-8A-24 (2020).

[242] The statute was amended effective in 2013 to change the duty from one of giving warning, to a duty to protect identifiable victims from patient violence as explained in statutory language explaining the amendment:

> (c) It is the intent of the Legislature that the amendments made by the act[1] adding this subdivision only change the name of the duty referenced in this section from a duty to warn and protect to a duty to protect. Nothing in this

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commit an act of violence. However, the statute providing for immunity builds upon *Tarasoff* and other California decisions that recognized the duty to warn or protect and, thus, serve to afford an important incentive for psychotherapists to comply with the judicially-created duty in responding to specific threats made by dangerous patients.

Dr. Felthous points out, moreover, that the California statute provides that the duty which will afford the therapist immunity is triggered only by a serious threat of violence directed at an identified or identifiable victim and not by any other assessment of the patient's propensity for violent action against others.[243] It is the specific threat that is the focus of the duty and concomitant protection contemplated by the statute.[244]

2. The "Permissive" Approach to the Duty to Warn or Protect

In contrast to legislative action directing mental health professionals to affirmatively act to protect third persons from injury threatened by dangerous patients, a minority of jurisdictions have adopted a "permissive" approach to the therapist's exercise of discretion, as the National Conference of State Legislatures notes.[245]

The permissive approach essentially assigns discretion for reporting a threat to the therapist but imposes *no duty* to report on therapists who are privy to the kind of specific threat that would entail liability for failure to warn under *Tarasoff*-like case law. But, the therapist may still be found liable if, in fact, the patient acts upon the

> section shall be construed to be a substantive change, and any duty of a psychotherapist shall not be modified as a result of changing the wording in this section.
> (d) It is the intent of the Legislature that a court interpret this section, as amended by the act adding this subdivision, in a manner consistent with the interpretation of this section as it read prior to January 1, 2013.

CAL. CIV. CODE § 43.92 (amended by 2012 Cal. Legis. Serv. ch. 149 (West)).

[243] Felthous, *supra* note 130, at 341.

[244] *See id.* ("*Tarasoff* statutes are typically mute on the matter of assessment and refer to threats as triggering events, not clinically established risks of violence.").

[245] *See Mental Health Professionals' Duty to Warn*, *supra* note 120, at 133, 186, 227, and accompanying text. In its survey of state statutes, the Conference characterized state laws governing reporting of confidential disclosures made by patients to therapists as either "mandatory," or "permissive." *Id.* A majority of jurisdictions, as indicated on the illustrated map, are characterized as "mandatory" reporting jurisdictions. *Id.*

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threat and commits an act of violence injuring a third party, if the jurisdiction recognizes a cause of action based upon patient acts injuring third parties.

Episodic mass violence may influence state legislatures to become more proactive in mandating warnings by mental health professionals, particularly if the continuing identification of mental illness as a cause for these acts induces the adoption of mandatory warning requirements by jurisdictions in which the legislature has been hostile to gun control efforts.

a. The Permissive Approach to Warning: Connecticut

The Connecticut statutory provisions addressing the duty to warn or protect reflect statutory changes in language applicable in 2019. The provision directed to "psychiatric health care providers" now reads:

> Communications or records *may be disclosed* when the psychiatric mental health provider determines that there is *substantial risk of imminent physical injury by the patient to himself or others or when a psychiatric mental health provider, in the course of diagnosis or treatment of the patient, finds it necessary to disclose the communications or records for the purpose of placing the patient in a mental health facility*, by certification, commitment or otherwise, provided the provisions of sections 52-146d to 52-146j, inclusive, as amended by this act, shall continue in effect after the patient is in the facility.[246]

This provision does not mandate notification of potential victims or police with respect to the potential for violence disclosed by patients during the course of treatment or therapy. Instead, it provides that the psychiatric mental health provider "may" disclose information raising a "substantial risk of imminent physical injury" that might be suffered by the patient or others. It, thus, reflects the *permissive* characterization described by the National Conference of State Legislatures.

Consistent with the permissive approach taken by the legislature, Connecticut courts have not recognized a *Tarasoff*-based cause of action for injuries sustained as a result of patient violence. In *Jarmie v. Troncale*,[247] the state supreme court generally observed, in considering the imposition of liability on health care

[246] CONN. GEN. STAT. ANN. § 52-146f (West 2020) (emphasis added). Sections 52-146d through 146j address confidentiality duties and circumstances in which reporting of confidential disclosures may be authorized.

[247] 50 A.3d 802 (Conn. 2012).

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providers: "There is no well established common-law rule that a physician owes a duty to warn or advise a patient for the benefit of another person."[248] The court then referenced state decisions in which liability for physicians, including mental health professionals, had not been imposed to support causes of action for injuries to third persons.[249] The court did note, however, its prior experience in considering *Tarasoff*-based liability in answering a certified question regarding state law respecting liability for patient injuries inflicted on third persons. The court explained:

> The only time that we have even *contemplated* enlarging the duty of a health care provider to include a person who is not a patient was when we considered whether a psychotherapist owed a duty to a third party to control an outpatient, who was not known to have been dangerous. In that case, we determined that no duty existed "in the absence of a showing that the victim was either individually identifiable or, possibly, was either a member of a class of identifiable victims or within the zone of risk to an identifiable victim." Accordingly, although there is no directly comparable Connecticut case law on which to rely, our precedent, in general, does not support extending the duty of care in the present case because, with one limited exception that does not apply . . . we repeatedly have declined, in a variety of situations, to extend the duty of health care providers to persons who are not their patients.[250]

The court provided a thorough discussion of policy considerations against the imposition of liability against health professionals for injuries sustained by third parties. In *Fraser*, the facts arose from the claimed negligence of a mental health professional in failing to anticipate violent behavior committed by an outpatient upon a victim not known to the therapist.[251] On those facts, the court declined to consider recognition of a broader theory of liability for mental health professionals. The court held that no duty to prevent injury would be imposed under Connecticut law in this situation based on the general rule that liability for negligence does not afford liability for injuries sustained by unidentifiable victims.[252]

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[248] *Id.* at 811.

[249] *Id.*

[250] *Id.* (quoting Fraser v. United States, 674 A.2d 811, 813–14 (Conn. 1996)).

[251] *Fraser*, 674 A.2d at 811.

[252] *Id.* at 814–15. The court explained more fully:

> Turning now to the merits of the certified question, we are persuaded that, as a matter of law in the circumstances of this case, the medical center

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The inference to be drawn from *Jarmie* and *Fraser* is that liability for injury committed by an individual being treated by a mental health professional upon a third person could, theoretically, afford liability for a therapist upon a showing that the therapist was aware of the identity of a potential victim. But the statute imposes no duty to warn even in such a situation, and the reasonableness of the psychiatric mental health professional's action in failing to warn might serve as a defense in a *Tarasoff*-based action.

The statute addressing the problem of potentially violent patients applicable for psychologists similarly does not mandate a duty to warn or protect third persons, providing:

> (c) Consent of the person shall not be required for the disclosure of such person's communications:
> . . .
> (3) If the psychologist believes in good faith that there is risk of imminent personal injury to the person or to other individuals or risk of imminent injury to the property of other individuals;
> (4) If child abuse, abuse of an elderly individual or abuse of an individual who is disabled or incompetent is known or in good faith suspected;[253]

This statute, like those governing disclosures of privileged communications made by patients during therapy or treatment with psychiatric mental health providers, provides only an exception to the confidentiality requirement. It does not direct the practitioner to warn a potential victim or law enforcement agency concerning an articulated or perceived threat by a patient to commit an act of violence. Nor does it

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> psychotherapists had no duty to exercise control over Doe to prevent him from assaulting Fraser. We reach this conclusion for four reasons: (1) our decisions defining negligence do not impose a duty to those who are not identifiable victims; (2) in related areas of our common law, we have concluded that there is no duty except to identifiable persons; (3) policy reasons inherent in the psychotherapeutic relationship and in the due process rights of mental patients counsel against imposing expansive duties to exercise control over such patients; and (4) courts in other jurisdictions have overwhelmingly declined to extend any duty to control to encompass harm to unidentifiable third persons.

Id.

[253] CONN. GEN. STAT. ANN. § 52-146c (West 2020). Section (a)(1) provides: "(1) 'Person' means an individual who consults a psychologist for purposes of diagnosis or treatment."

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expressly immunize the therapist from liability to third persons injured by a violent patient based on a report or determination not to report.

This consideration is significant because the Connecticut Supreme Court unequivocally explained its concern that the issuance of warnings by mental health professionals will jeopardize the trust relationship necessary for effective treatment. The court explained in *Jarmie*, for instance, that litigation brought by third persons based on lack of warning of potential danger as a result of patient action would expose the patient to the disclosure of confidential information related to the therapist sued by a third party during the course of treatment.[254] But the facts in the case were hardly as egregious as those in *Tarasoff* because the negligence claim involved a failure of a physician to warn the patient of the risk of accident due to the effects of prescribed medication.[255] Even given the factual disparity between the claimed negligence in these cases, however, the Connecticut Supreme Court's concern for expanding physician liability and its potential consequences for impairing the trust relationship necessary for successful treatment is apparent.[256] The court explained:

> [E]xtending the duty of physicians, as the plaintiff suggests, would impermissibly interfere with the physician-patient relationship.
> The proposed duty also would result in increased litigation because it would open the door to an entirely new category of claims against health care providers, not only in the present context, but in the context of other treatment decisions that might indirectly cause injury to third parties, thereby greatly expanding the liability of health care providers and creating an additional burden on the courts.[257]

The court's response to the question certified by the federal court in *Fraser*, however, clearly indicates that a true *Tarasoff* circumstance, including the identification of a specific victim by a patient whose ability to act upon a threat to consider violence should have been deemed credible, would support a claim for negligence in the therapist's failure to warn or take other action to protect the victim.

[254] Jarmie v. Troncale, 50 A.3d 802, 820–21 (Conn. 2012).

[255] *Id.* at 804.

[256] *Id.* at 821–23.

[257] *Id.* at 822–23.

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b. A Hybrid Approach to Warning: Florida

The Florida statutory scheme retains an important element of discretion for the mental health provider, although the precise language of the current statutory scheme suggests that the *permissive* characterization of the state approach may be in flux. Three statutory provisions describe the expectations of psychiatrists,[258] psychologists,[259] and other mental health providers,[260] respectively. Section 90.503 recognizes a general requirement for confidentiality applicable to mental health providers.[261] However, the statutes addressing the confidentiality of communications between patients and psychiatrists and psychologists specifically recognize the option for those mental health professionals to warn third persons targeted for violence by patients.[262] For instance, § 546.059 provides that when a psychiatrist learns of "a specific threat to cause serious bodily injury or death to an identified or a readily available person"[263] he or she "*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."[264] The statutory scheme thus affords the psychiatrist discretion in disclosing a patient threat to the intended victim, making this a *permissive* legislatively-recognized duty in one sense; but, the scheme is also *mandatory* because the psychiatrist has an affirmative duty to report the threat to a law enforcement agency. Section 459.059(3) then requires affirmative action by the agency warned, providing, "a law enforcement agency that receives notification of a specific threat under this section must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order."[265]

The mandatory report to law enforcement serves to shift the duty to protect the third party identified in the patient's threat from the treating psychiatrist to an agency charged with prevention of violence, which may well be more effective than a direct warning from the physician in terms of defusing a potentially violent situation. This

[258] FLA. STAT. ANN. § 456.059 (West 2020).

[259] § 491.0147.

[260] § 90.503.

[261] § 456.059. The statutorily-defined rule recognizing evidentiary privilege recognizes the duty to maintain confidentiality for patient disclosures and includes the range of mental health professionals typically involved in treatment for mental illness or emotional problems, including physicians engaged in the diagnosis or treatment of a mental or emotional condition, such as alcoholism and other drug addiction; psychologists; licensed or certified clinical social workers, marriage and family therapists, or mental health counselors. § 90.503(A)(1)(a).

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shift does not necessarily avoid the patient's sense that the trust relationship with the treating professional has been compromised, even when law enforcement, rather than the psychiatrist, takes whatever action may be appropriate. If, for example, the warning or proactive action taken includes a law enforcement officer's direct confrontation with the patient, the patient may still conclude that their treating professional has breached the duty of confidentiality in disclosing the threat to law enforcement, even if there is no personal warning to the prospective victim from the treating psychiatrist directly.

On the other hand, the statute appears to provide an important level of protection for potential victims of patient violence by bringing law enforcement into the situation in which the treating psychiatrist has concluded that the patient's threat is credible. The statute requires that threats that warrant disclosure breaching confidentiality involve "a clinical judgment that the patient has the apparent intent and ability to imminently or immediately carry out such threat."[266]

Similarly, confidential communications involving patient threats of violence directed at third persons may warrant action by psychologists to warn those potential victims under § 490.0147.[267] The statute provides that confidentiality of disclosures made to a psychologist may be waived:[268]

> (c) When a patient or client has communicated to the psychologist a specific threat to cause serious bodily injury or death to an identified or readily available person, and the psychologist makes a clinical judgment that the patient or client has the apparent intent and ability to imminently or immediately carry out such threat, and the psychologist communicates the information to the potential victim. A disclosure of confidential communications by a psychologist when

[262] *See, e.g.*, § 456.059 (governing the confidentiality duty imposed on psychiatrists, which expressly modifies the general duty to maintain patient confidences protected by the statutory privilege created by Section 90.053 with respect to disclosure of threatened violence by patients).

[263] § 456.059(2)–(3) (The duty to warn is premised on a finding that the "treating psychiatrist makes a clinical judgment that the patient has the apparent intent and ability to imminently or immediately carry out such threat. . . .").

[264] *Id.* (emphasis added).

[265] *Id.*

[266] *Id.*

[267] § 456.0147.

[268] § 456.0147(1).

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> communicating a threat pursuant to this subsection may not be the basis of any legal action or criminal or civil liability against the psychologist.[269]

The provision protects the therapist by providing that disclosure is necessitated by the determination that the patient has both the *intent* and *ability to carry out such threat*. It does not, however, mandate disclosure of the intended threat to the potential victim disclosed by the patient; instead, the guarantee of immunity serves to encourage the therapist to act affirmatively to warn the intended victim. Parallel to the duty imposed on a psychiatrist, the statutory scheme mandates disclosure of the threat to cause serious bodily injury or death to "the extent necessary to communicate the threat to a law enforcement agency."[270]

Significantly, the statutory scheme also mandates that a law enforcement agency notified of a patient's threatened violence "must take appropriate action to prevent the risk of harm, including, but not limited to, notifying the intended victim of such threat or initiating a risk protection order."[271] This provision serves to protect a therapist issuing the required warning to law enforcement about potential patient violence from civil liability. The fact that the therapist has warned law enforcement implies, of course, that the therapist has concluded that the threat of violence is serious and that the patient is believed to have the ability to carry out the threat. Thus, the statutory immunity from civil liability promotes the public policy of protecting third persons from violence committed by patients being treated by mental health professionals. It also protects the therapist issuing the warning to law enforcement from civil liability for disclosing the basis for the conclusion that the expression of violent intent is both seriously expressed and accompanied by the ability to carry out the threat.[272]

The Florida approach thus defers to the mental health professional's assessment of the credibility of the patient's threat in light of the perceived seriousness of intent to actually commit a violent attack toward an identified or readily available person and the patient's ability to act on the threat. Once the therapist involves law enforcement by disclosing the threat, the statutory scheme directs law enforcement officers to act upon the threat, rather than engage in any consideration of the seriousness of the threat that has been disclosed, presumably in an effort to ensure that the breach of patient/therapist confidentiality implicit in the referral by the

[269] § 456.0147(1)(c).

[270] § 456.0147(2).

[271] *Id.*

[272] *Id.*

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mental health professional is not functionally ignored. Action by law enforcement is required to protect the potential victim but also warrants immunity for the treating psychiatrist or psychologist whose professional judgment has led to the referral. Thus, the balance between the need for confidentiality and protection of third persons is resolved in favor of protection by theoretically, at least, assuring that such disclosures will not go unheeded while possibly compromising the patient's expectation of confidentiality.

3. The Arkansas Immunity Model

Another example of the *permissive* approach to the mental health professional's duty to warn or protect is reflected in the expanded immunity afforded to Arkansas professionals by statute. The Arkansas General Assembly attempted to address the interrelated problems of mental impairment and violence with the passage of Act 1212 in the 2013 General Session,[273] but not by targeting firearms possessed by potentially dangerous individuals or patients. Instead, it did so by offering the community of mental health providers statutory immunity for preventive action taken to prevent violence by patients against third persons or themselves. Mental health providers are defined in § 201(4) of the statute as "a licensed certified social worker, licensed marriage and family therapist, licensed professional counselor, physician, psychologist, or registered nurse who provides mental health services. . . ."[274]

The General Assembly intended to further the goal of preventing acts of violence, including mass violence, by creating immunity for "mental health services providers" who comply with the statutory directive to report potential patient violence to law enforcement agencies. Section 202(b) provides:

> (b) A duty owed by a mental health services provider to take reasonable precautions to prevent harm threatened by a patient is discharged, as a matter of law, if the mental health services provider in a timely manner:
> (1) Notifies:
> (A) A law enforcement agency in the county in which the potential victim resides;
> (B) A law enforcement agency in the county in which the patient resides; or

[273] 2013 ARK. ACTS 4964 (codified at ARK. CODE ANN. § 20-45-201 to 202 (2013)). Section 202 is titled: "Duty of mental health services provider to take precautions against threatened patient violence—Duty to warn." ARK. CODE ANN. § 20-45-202.

[274] § 20-45-201(4).

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> (C) The Department of Arkansas State Police; or
> (2) Arranges for the patient's immediate voluntary or involuntary hospitalization.[275]

Section 202(a) creates the statutory immunity from civil liability based on harm to third persons or property, provided the provider makes the appropriate report:

> A mental health services provider, hospital, facility, community mental health center, or clinic is *not subject to liability, suit, or a claim* under § 19-10-204 on grounds that a mental health services provider did not prevent harm to an individual or to property caused by a patient if:
> (1) The patient communicates to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly or reasonably identifiable potential victim or to commit a specific violent act or to destroy property under circumstances that could easily lead to serious personal injury or death and the patient has an apparent intent and ability to carry out the threat; and
> (2) The mental health services provider takes the precautions specified in subsection (b) of this section in an attempt to prevent the threatened harm.[276]

Although the title of the statute indicates that it is designed to create or recognize a duty to warn, the statutory language fails to define the duty or its scope. Instead, subsection (b) merely refers to "*A duty* owed by a mental health services provider to take reasonable precautions to prevent harm threatened by a patient."[277] It seemingly refers to a duty that had yet to be defined in either judicial decision or by another statutory provision at the time of Act 1212's adoption. Arguably, the decision by the Arkansas Court of Appeals in *Fleming v. Vest*,[278] which rested on differing grounds argued by the majority and concurring judges,[279] necessarily

[275] § 20-45-202(b).

[276] § 20-45-202(a) (emphasis added). Section 19-10-204 authorizes claims against the State otherwise barred by the doctrine of sovereign immunity. § 19-10-204. Thus, the immunity afforded under the statute extends to claims against state actors or institutions and precludes an action in the Arkansas Claims Commission when the mental health professional has made the appropriate warning.

[277] § 20-45-202(b) (emphasis added).

[278] 475 S.W.3d 576, 580 (Ark. Ct. App. 2015). *See* Sullivan, *supra* note 124, at 1022–43 (noting that the decision was not rendered by the Arkansas Supreme Court and reflected disagreement among judges as to the appropriate theory of liability, if any, based on the facts of the case).

[279] *Id.* at 1026–35. The majority of the appellate court's panel held that the duty was inferred from the state's medical malpractice statute, while the concurring judge rejected the argument that the duty to warn

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involved recognition of a duty owed by mental health professionals to warn or protect third persons from patient violence.

The passage of Act 1212 appears to further the goal of preventing harm to third parties or property, but it likely will prove troubling for mental health providers who must make decisions based on violence risk assessments. It creates, perhaps by necessity, a policy balancing act in which mental health providers are given primary responsibility for these precautionary decisions—which are particularly difficult because of the lack of certainty in predicting violence—that must be made in the context of the confidential relationship between the provider and the patient.

Subsection (a) of the statute implicitly recognizes that mental health providers are subject to civil liability for injuries sustained by third persons or, arguably, the patient, as a result of violence committed by the patient.[280] By focusing the protection presumably afforded by the warning requirement on the mental health professional's opportunity to secure immunity from civil liability, the statute has likely created immunity for the mental health provider not previously recognized under state law.[281] But, in the only Arkansas decision to even mention *Tarasoff*, *Fleming v. Vest*[282]—and then, only in the concurring opinion—[283]there is no clear expression of the duty that will render a mental health professional liable for injuries imposed by a patient who has threatened violence.[284] In fact, the split in the court of appeals panel

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third persons arose in the context of treating a patient, but rather was based on general negligent concepts. *Id.* Moreover, the appellate court's review was based on two procedural issues involving the applicable statute of limitations for Fleming's Estate's claim and the application of the summary judgment test for sufficiency of the evidence to establish a cause of action under state law. *Id.*

[280] ARK. CODE ANN. § 20-45-202(a).

[281] § 20-45-202. Section 202 of the Arkansas statute is titled: "Duty of mental health services provider to take precautions against threatened patient violence—Duty to warn." *Id.* The title suggests nothing less than mental health professionals are under a duty to warn or protect third persons from patient-inflicted injuries.

[282] 475 S.W.3d 576.

[283] *Id.* at 584.

[284] In the Arkansas Court of Appeals the case turned on whether the two-year statute of limitations for medical malpractice claims, Arkansas Medical Malpractice Act, ARK. CODE ANN. §§ 16-114-201 to -203, or the three-year limitations period for negligence claims applied to the Estate's action. *Fleming*, 475 S.W.3d at 580. Perhaps surprisingly, the majority opinion does not directly address the issue of liability to third parties. *See id.* Instead, this issue is entangled in the discussion of other issues, including the applicability of the Medical Malpractice Act and its two-year statute of limitations. *Id.*; ARK. CODE ANN. § 16-114-203(a). Instead, Judge Harrison in his concurring opinion actually opens the door to the fundamental question of liability for claims made by third parties: "What duty, if any, did Dr. Vest owe to Fleming under the circumstances? That is the underlying issue in this case, and courts have split over

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was particularly significant because the opinions issued by the majority and concurring judges do not make clear that the psychiatrist, Dr. Vest, was even aware of the violent tendency of his patient, or that the patient had made any threat that would have logically triggered a warning designed to prevent injury to the deceased, Fleming, who was apparently unknown to Dr. Vest.

If the mental health provider is "*not* subject to liability, suit or claim under § 19-10-204" when the provider complies with the directive to notify authorities of the potential for violence posed by a patient, then the logical corollary is that a provider *not* notifying authorities can be held liable for injuries caused by patient violence.[285]

Because the recognition of a cause of action against mental health providers who fail to properly assess a risk of violence or fail to report potential violence on the part of their patients represents a significant development in Arkansas law that bears directly, and perhaps, somewhat adversely, on the relationship of mental health professionals and their patients, its unintended consequences are particularly important. In failing to address the parameters of the obligation on the part of mental health professionals seeking to avail themselves of the statutory immunity, the statute fails to actually afford the notice that would have at least informed Dr. Vest that he would owe a duty to third persons injured by his patients, even when they were otherwise unknown or not disclosed in the course of treatment of the patient, or when the patient had never expressed a threat to commit any act of violence. The breadth of the holding in *Fleming v. Vest*, in light of the lack of reference to facts supporting a claim of negligence or medical malpractice on the psychiatrist's part, would seemingly create an unlimited source of strict liability for mental health practitioners whose patients injure others, without a required showing of any knowledge of a patient's violent tendencies or specific anger toward any particular individual.

The statutory immunity scheme is also inherently flawed for a number of reasons. There is an absence of either statutory language or judicial decisions that clearly notify mental health providers of the precise parameters of their professional duty to protect third persons from injuries committed by their patients. Yet, that is the stated legislative purpose for the protection it affords, given the title of the statute:

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this question since the seminal case *Tarasoff v. Regents of University of California*." *Fleming*, 475 S.W.3d at 584 (Harrison, J., concurring).

[285] *See* ARK. CODE ANN. § 20-45-202(a).

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"Duty of mental health services provider to take precautions against threatened patient violence—Duty to warn."[286]

First, the duty to warn may be discharged by the treating professional by a disclosure of actual or perceived threat by reporting the therapist's concern to an appropriate law enforcement agency.[287] The statutory immunity scheme fails to appreciate an intended or prospective victim's need for the very information that might facilitate avoidance of danger or confrontation with the patient. Although in *Tarasoff* the mental health professionals alerted police to the need to confine Poddar, the assailant, for emergency commitment, his intended victim was not personally informed, leading the court to point out, tersely: "No one warned Tatiana of her peril."[288] While reporting a threat or perceived threat of violence to law enforcement might appear to secure the safety of the potential victim to a significant extent, the potential victim's safety is wholly dependent upon law enforcement to take some action contemplated by the statute, beyond the responsibility of the mental health professional.[289] Yet, the contemplated action on the part of law enforcement may not happen at all, perhaps because of internal communication failure within the policing agencies to whom the threat is disclosed.[290] Or, the officers charged with acting upon

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[286] ARK. CODE ANN. § 20-45-202.

[287] § 20-45-202(b)(1). See *supra* note 281 for text of statutory provision permitting the mental provider to discharge their duty to report a patient's threat to commit an active of violence against a third person, or persons, by reporting the threat to a law enforcement agency having authority in the jurisdiction where the intended victim—if identified—lives or to the Arkansas State Police, pursuant to § 101(b)(1)(c).

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

[289] *See, e.g.*, FLA. STAT. ANN. §§ 456.059(3), 456.0147(2). In contrast to the Florida scheme, the Arkansas statute does not include any directive to law enforcement regarding the required response by law enforcement when a mental health professional does report a threat of potential patient violence directed toward an identified individual or general threat.

[290] The immunity statute does not include any directive to law enforcement regarding specific duty to act on the threat or perceived threat reported by the mental health professional, nor does it refer to specific action that may be taken. Law enforcement officers do have a general duty to arrest insane and drunken persons under ARK. CODE ANN. § 20-47-101:

> It shall be the duty of all peace officers to arrest any insane or drunken persons whom they may find at large and not in the care of some discreet person. The officer shall take him or her before some magistrate of the county, city, or town in which the arrest is made.

If the therapist, or any other person, petitions for the emergency confinement of an impaired, dangerous person under the Arkansas civil commitment statute, ARK. CODE ANN. § 20-47-201, the probate court may order law enforcement authorities to act specifically to address the situation, as provided for:

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the threat may simply conclude that action is not required. In *Tarasoff*, for instance, the officers who were to take Poddar into custody for emergency hospitalization to protect Tatiana confronted him and decided that he did not exhibit threatening behavior warranting arrest.[291] He later murdered Tatiana, precipitating the lawsuit.

While reporting to law enforcement would logically provide information concerning the patient's potential for violence, in the absence of a specific threat, it is simply not necessarily the case that the report will result in any action unless and until the impaired patient actually commits a criminal offense.[292] Or, even if a law

> (a) Whenever it appears that a person is of danger to himself or herself or others, as defined in § 20-47-207, and immediate confinement appears necessary to avoid harm to the person or others:
>
> (1) *An interested citizen* may take the person to a hospital or to a receiving facility or program. *If no other safe means of transporting the individual is available, it shall be the responsibility of the law enforcement agency that exercises jurisdiction at the site where the individual is physically located and requiring transportation, or unless otherwise ordered by the judge.* A petition, as provided in § 20-47-207, shall be filed in the probate court of the county in which the person resides or is detained within seventy-two (72) hours, excluding weekends and holidays, and a hearing, as provided in § 20- 47-209(a)(1) shall be held;
>
> . . .
>
> (b)(1) When a petition for involuntary admission with a request for immediate confinement appended thereto is filed, the petitioner shall then appear before a probate judge of the county where the person sought to be immediately confined resides or is found.
>
> . . .
>
> (3) If the probate judge determines that immediate confinement is necessary to prevent death or serious bodily harm to either the person sought to be involuntarily admitted or to others, *the judge shall order the law enforcement agency that exercises jurisdiction at the site where the individual is physically present to transport the individual to an appropriate receiving facility*. A hearing, as provided for in § 20-47-209(a)(1), shall be held within seventy-two (72) hours of the person's detention and confinement.

ARK. CODE ANN. § 20-47-210 (a)(1), (b)(1), (b)(3) (emphasis added).

[291] *Tarasoff*, 551 P.2d at 339–40.

[292] Like the failure of law enforcement in *Tarasoff*, law enforcement officials notified of the psychotic threats made by Elliot Rodger, perpetrator of the Santa Barbara, California, rampage of stabbings and shootings in May 2014, either ignored his family's warnings of his potential for violence or failed to appreciate the his extremely aberrant thinking, resulting in their failure to take appropriate action to restrain him. In reviewing the failure of law enforcement, CBS News reported:

> Just three weeks before his murderous rampage, Rodger met sheriff's deputies at his door.

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enforcement officer intervenes proactively, the disclosure that a threat has been reported can likely have little effect if the impaired patient is intent upon committing an act of violence against another person or herself. Moreover, an officer's well-intentioned intervention might serve to precipitate action by the impaired patient that might otherwise not have been undertaken.

The intervention by a law enforcement officer almost certainly will result in the patient understanding that their treating professional has reported threats or threatening information disclosed in the context of the confidential relationship. This could lead to retaliation against the mental health professional treating the patient, perhaps including violent retaliation or litigation, and would very likely jeopardize the relationship between the patient and therapist, compromising a critical element for success in treatment. Once the patient's trust in the protection of confidential communications afforded by the patient/therapist relationship has been compromised by warning, it may not only destroy the relationship with the therapist who has warned but may also serve to prevent the patient from ever trusting a mental health professional in the future.[293]

Subsection (c)(1) references the traditionally recognized recourse for the mental health professional in addressing violence or credible threat of violence disclosed during the course of therapy: emergency hospitalization.[294] This provision is redundant to existing immunity afforded to mental health professionals and all other persons acting in good faith in the emergency hospitalization or involuntary

> Relatives had seen Rodger's threatening Internet posts, and they notified a social worker, who alerted police.
> Sheriff Brown told CBS' "Face the Nation" on Sunday: "Rodger was polite and courteous to his officers."
> "He was able to make a very convincing story that there was no problem, that he wasn't going to hurt himself or anyone else. He just didn't meet the criteria for any further intervention at that point."

Despite Warning Signs, Cops Saw No Threat In Elliot Rodger, CBS NEWS (May 26, 2014, 1:21 PM), https://www.cbsnews.com/news/santa-barbara-massacre-despite-warning-signs-cops-were-handcuffed-in-elliot-rodger-case/.

[293] *See* Jaffee v. Redmond, 518 U.S. 1 (1996); *supra* notes 98–104 and accompanying text.

[294] ARK. CODE ANN. § 20-47-207(c)(1), authorizes involuntary civil commitment for hospitalization in order to address potential violence committed by mental impairment, as provided generally: "Involuntary Admission Criteria. A person shall be eligible for involuntary admission if he or she is in such a mental condition as a result of mental illness, disease, or disorder that he or she poses a clear and present danger to himself or herself or others."

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civil commitment process under Arkansas law.[295] With respect to the option of petitioning for emergency restraint of an individual credibly meeting the requirement of involuntary hospitalization for mental evaluation and treatment, Act 1212 creates no additional express duty upon mental health professionals to warn or take action to prevent violence directed at third persons, or generally, doing little to enhance protection for the community while ensuring protection from civil liability for those professionals who do elect to issue warnings.

The problem posed by the structure of the Arkansas statute is that warnings ensuring civil immunity become the default position for mental health professionals. Ultimately, this approach could elevate the value of the warning above the professional concern for confidentiality of patient communications. Logically, this default position could so threaten the therapeutic environment necessary for those professionals to address patient frustration and anger that can materialize as violent action that mental health treatment would be irreparably impaired by the pressure to avoid civil liability by resorting to warnings that would not otherwise be necessary as matters of professional judgment.

V. PROBLEMS INHERENT IN IDENTIFYING RISK OF VIOLENCE WARRANTING PROTECTIVE ACTION

Tarasoff, carefully limited to its facts, requires threat disclosure or other action only when the mental professional is able to assess the credibility of a patient's threat and perform an assessment of the patient's capability to actually act on the hostility or threat. For instance, inquiry regarding the patient's experience with and access to firearms or other weaponry may prove a critical factor in the assessment not only of the seriousness of the patient's disclosed hostility or threat but also the likelihood that they would have the resources to act upon the threat.[296] Consequently, a threat expressed by a patient confined in a hospital or correctional facility may well be genuine in terms of the patient's intent but less likely to be actualized because of the circumstances in which the mental health professional interacts with the patient.

A. Circumstances Giving Rise to the Duty to Warn or Protect, Generally

Tarasoff arose in perhaps the most obvious factual scenario in which liability for mental health professionals could be imposed. There was evidence of a specific

[295] § 20-47-227 ("Exclusion from liability. No officer, physician, or other person shall be held civilly liable for his or her actions pursuant to this subchapter in the absence of proof of bad faith, malice, or gross negligence.").

[296] Experience with firearms or access to firearms is described as a "situational variable," a dynamic variable in the assessment of the risk of patient violence. COHEN, *supra* note 82, at 451.

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threat to commit an act of violence. The threat arose in the context of a common context in which significant anxiety is likely to be experienced by patients—the failure of an interpersonal relationship, whether fantasized or initially reciprocated. The identity of the intended victim was disclosed. And finally, the treating psychologist's initial response to the threat—an attempt to have the patient taken into custody for purposes of further evaluation and treatment through emergency hospitalization, if warranted—demonstrated the therapist's conclusion of the seriousness of the perceived risk of violence. In this complex of facts, the imposition of liability that would require affirmative action by the therapist could readily be justified in terms of foreseeability analysis and the existence of the special relationship upon which the therapist's duty rested.[297]

The specificity of the threat expressed by the patient may also suggest the appropriateness of the finding of a duty to warn or protect. In *Peck v. Counseling Service of Addison County, Inc.*,[298] John, an outpatient irritated by his father's description of him as "sick and mentally ill," left his home and went to see his psychotherapist.[299] He explained his anger toward his father, and when questioned about whether he intended to "get back at his father," he told the therapist, "I don't know. I could burn down his barn."[300] After further discussion with the psychotherapist, the patient promised not to burn the barn.[301] "Believing that John would keep his promise, the therapist did not disclose John's threats to any other

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[297] It is the "special relationship" that triggers the duty to act on the part of the mental health profession in the *Tarasoff* reasoning, warranting a departure from the common law rule: "[U]nder the common law, as a general rule, one person owed no duty to control the conduct of another." Tarasoff v. Regents of Uni. of Cal., 551 P.2d 334, 343 (Cal. 1976). The majority explained that the common law rule has given way to expansion of duty to protect against injury:

> Morally questionable, the rule owes its survival to "the difficulties of setting any standards of unselfish service to fellow men, and of making any workable rule to cover possible situations where fifty people might fail to rescue . . ." . . . . Because of these practical difficulties, the courts have increased the number of instances in which affirmative duties are imposed not by direct rejection of the common law rule, but by expanding the list of special relationships which will justify departure from that rule.

Id. at 343 n.5 (quoting WILLIAM PROSSER, HANDBOOK OF THE LAW OF TORTS 341, 348–50 (4th ed. 1971)).

[298] 499 A.2d 422 (Vt. 1985).

[299] *Id.* at 424.

[300] *Id.*

[301] *Id.*

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staff member of the Counseling Service or to the plaintiffs [John's parents]."[302] John apparently forgot the promise. Or, perhaps he just lied.

The Vermont court rejected the defendants' reliance on Professor Stone's assertion that therapists have no control over outpatients,[303] citing *Tarasoff*[304] and explaining:

> Whether or not there is actual control over an outpatient in a mental health clinic setting similar to that exercised over institutionalized patients, the relationship between a clinical therapist and his or her patient "is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct."[305]

The court found the disclosed threat necessitated warning or other action to prevent the injury, but also upheld the trial court's finding that the parents, clearly aware of their son's propensity for violence, were fifty percent comparatively negligent.[306] While the court did not evaluate the role of the specific nature of the patient's threat—to burn the barn—it would seem reasonable that the parent's appreciation of their son's violent tendencies did not absolve the defendants' liability because he followed through on the precise threat he had made—the *burning of the barn*, much like the specific threat made by Poddar to *kill* Tatiana in *Tarasoff*.[307]

But the fact complex presented in *Tarasoff* is simply not shared in many cases in which patient dangerousness or articulated threats to commit acts of violence materializes in acts of physical violence committed against third persons. This is perhaps most remote when the patient's violence is random, not being directed toward those who are the most obvious sources of anxiety and hostility for the patient. Realistically, the duty imposed upon treating therapists should be viewed not only in terms of the expectation for skilled assessment of the risk of patient violence, but also on sheer reasonableness in assuming that a therapist can anticipate the scope

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[302] *Id.*

[303] Stone, *supra* note 126, at 366.

[304] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 343 (Cal. 1976).

[305] *Peck*, 499 A.2d at 425 (citing *Tarasoff*, 551 P.2d at 343).

[306] *Id.* at 427.

[307] 551 P.2d at 339.

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of an act of patient violence when there has been no express identification of prospective targets or an express threat.

Significantly, the California Supreme Court addressed the scope of the duty to warn or protect shortly after *Tarasoff* in *Thompson v. County of Alameda*,[308] a 1980 decision arising out of an assault committed by a juvenile offender released from detention who had exhibited violent tendencies toward younger children. Within twenty-four hours of the offender's release by County authorities, who had been aware of his propensity and professed interest in killing a child—and who had not notified the offender's mother of his desire to kill a neighborhood child—the offender killed a five-year-old whose family lived a few doors from the offender's residence.[309]

The juvenile murderer had not disclosed the identity of his potential victim to authorities prior to his release from custody.[310] In response to the plaintiff's claims that the County was grossly negligent in releasing the offender from custody, the state supreme court held that the decision to release was subject to immunity under state law.[311] The court similarly held that the County was immune from liability for the decision to release the juvenile offender to the custody of his mother and any failure to supervise her subsequent actions.[312] The court explained:

> Choosing a proper custodian to direct the attempted rehabilitation of a minor with a prior history of antisocial behavior is a complex task. The determination involves a careful consideration and balancing of such factors as the protection of

[308] 614 P.2d 728 (Cal. 1980).

[309] *Id.* at 746.

[310] *Id.*

[311] *Id.* at 747–48. Similarly, in *Tarasoff*, the University health clinic professionals were afforded the benefit of statutory immunity typically given to encourage mental health professionals to make decisions regarding involuntary civil commitment for purposes of treatment for prospective patients suffering from mental disorders who present a threat to commit acts of violence to themselves or others. 551 P.2d at 351–52. The campus police officers who decided not to take Poddar into custody on request from the University psychologist were also shielded by statutory immunity based on their actions in the emergency commitment process. *Id.* at 353. Statutory immunity afforded actors in the emergency commitment process is common. *See, e.g.*, ARK. CODE ANN. § 20-47-227 (2020) (giving immunity to "officer[s], physician[s], or other person[s]" involved in seeking involuntary civil commitment of a mentally impaired individual believed dangerous "in the absence of proof of bad faith, malice, or gross negligence"); WASH. REV. CODE § 10.31.110(6) (2020) (giving immunity to police officers acting in good faith when arresting individual with mental disorders).

[312] *Thompson*, 614 P.2d at 738.

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> the public, the physical and psychological needs of the minor, the relative suitability of the home environment, the availability of other resources such as halfway houses and community centers, and the need to reintegrate the minor into the community. *The decision, requiring as it does, comparisons, choices, judgments, and evaluations, comprises the very essence of the exercise of "discretion"* and we conclude that such decisions are immunized under section [CAL. GOV'T CODE] 820.2.[313]

The court characterizes the complexity of decision-making with respect to the evaluation of a minor who has engaged in antisocial behavior; but the considerations the court noted above likely influence every decision that must be made by mental health professionals when addressing potential violence expressed or suggested by dangerous patients.

The court then considered the question of whether the failure of County officials to warn characterizing this as the most "troublesome contention" advanced by the plaintiffs.[314] The court did not, however, find that the public officials or officers violated of a duty to the plaintiffs in the case. Rather, it distinguished the facts from a prior decision in *Johnson v. State of California*,[315] in which the state agency was found liable when it placed a minor with known "homicidal tendencies" and a history of violence in the plaintiff's home.[316] The *Thompson* court distinguished the factual scenario in *Johnson* based on the existence of a *special relationship* in the earlier case rooted in the placement of the juvenile with the plaintiff, explaining:

> As the party placing the youth with Mrs. Johnson, the state's relationship to plaintiff was such that its duty extended to warning of latent, dangerous qualities suggested by the parolee's history or character. These cases [*Johnson* and *Tarasoff*] impose a duty upon those who create a foreseeable peril, not readily discoverable by endangered persons, to warn them of such potential peril.

[313] *Id.* at 732 (emphasis added) (citations omitted).

[314] *Id.* at 731–32.

[315] *Id.* at 733.

[316] Johnson v. California, 447 P.2d 352 (Cal. 1968).

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> Accordingly, the state owed a duty to inform Mrs. Johnson of any matter that its agents knew or should have known that might endanger the Johnson family.[317]

The facts in *Thompson* were different, according to the court, because the public officials or officers involved in the decision to release the dangerous juvenile had no *special relationship* with the family of the child who was murdered shortly after the juvenile's release.[318] It concluded that the "County bore no special and continuous relationship with the specific plaintiffs nor did [the] County knowingly place the specific plaintiffs' decedent into a foreseeably dangerous position."[319]

Based on the lack of a special relationship between authorities and the family of the murdered child and the fact that there was no identification of a specific victim of the juvenile's intended act of violence, the *Thompson* court refused to impose liability on the County for failure to warn of the juvenile's violent propensity.[320] It expressed skepticism that extensive, general warnings would have significant practical benefit in avoiding potential danger to the public, noting the difference between general warnings and scenarios where knowledge of specific potential victims who might logically be protected by discrete warnings, as in fact situations presented in *Tarasoff* and *Johnson*.[321] Consequently, the court declined to find that the violence was foreseeable and rejected the plaintiff's theory of liability.[322]

Noting the legislatively imposed registration obligation for sex offenders released on probation or parole, the court pointed out that even in this context, the legislation did not require authorities to notify the community of the presence of a sex offender or otherwise supervise the offender.[323] Further, the legislative immunity granted to public entities which precluded liability for confinement or release of dangerous persons applied in *Thompson*, but the court's conclusion also precluded

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[317] *Thompson*, 614 P.2d at 733 (emphasis omitted) (citing *Johnson*, 447 P.2d at 355).

[318] *Id.* at 733.

[319] *Id.*

[320] *Id.* at 734.

[321] *Id.*

[322] *Id.* The court also found that the plaintiff's murdered child was not "a foreseeable or readily identifiable target of the juvenile offender's threats." *Id.*

[323] *Id.* at 736–37 (citing CAL. PENAL CODE § 290 (West 2020)).

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liability even had the statutory provision not been controlling,[324] reasoning from both foreseeability analysis and public policy.[325]

Although the *Thompson* court's reliance on the controlling legislative grant of immunity for public entities and officials was clearly required, it is less clear that imposition of a duty to warn, rather than a duty to protect based on continuing confinement of the dangerous individual, was consistent with the underlying theory of duty embraced in *Tarasoff* and *Johnson*. The juvenile offender released in *Thompson* had expressed a specific intent to commit an act of violence even though no specific victim had been identified. As a minor, he was more likely restricted to a neighborhood than might have been true had he been an adult. A warning to neighbors living within a reasonably close distance to the juvenile and his mother could have provided a strong potential for protection of young children in the neighborhood; a general warning to the entire community would not have been necessary to significantly increase awareness of the possibility that the offender would target neighborhood children.

This approach reflects the position advanced by Justice Tobriner, the author of the majority opinion in *Tarasoff*, in his dissent in *Thompson*.[326] He chided the majority's limited understanding of the foreseeability principle applied in *Tarasoff*, arguing:

> The complaint alleges that James had threatened to "take the life of a young child residing in the neighborhood"; *since Jonathan falls within that description his killing was clearly a foreseeable consequence of James' release and subsequent lack of supervision.* Whether Jonathan was also an identifiable victim is relevant

[324] *Id.* at 732.

[325] The court explained that public policy considerations weighed against liability for decisions made regarding release of even those individuals who had been convicted of crimes of violence in the criminal justice system:

> [P]ublic entities and employees have no affirmative duty to warn of the release of an inmate with a violent history who has made nonspecific threats of harm directed at nonspecific victims. Obviously aware of the risk of failure of probation and parole programs the Legislature has nonetheless as a matter of public policy elected to continue those programs even though such risks must be borne by the public.

Id. at 735 (emphasis omitted).

[326] *Id.* at 738.

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> not to the existence of a duty of care, but only to whether a warning to Jonathan personally was a reasonable means of discharging that duty.[327]

For Justice Tobriner and Justice Mosk, joining the dissent, the specific threat was the critical element factoring into the foreseeability analysis, not the identification of a specific, intended victim.[328] Imposing liability on a mental health professional for failing to warn the neighborhood of the threat posed by the release of the dangerous juvenile might have been seen as unfair in terms of public policy because it extended the duty to warn to unidentified, potential victims. However, liability for damages would not have been borne by an individual defendant suffering retroactive application of a new rule. Instead, economic damages would have been spread throughout the community, necessarily leading to the development of sound public policy for limited warnings to be afforded to potential victims in similar situations.

An interesting example of treatment of the foreseeability issue is illustrated in a recent decision rendered by the Vermont Supreme Court. In *Kuligoski v. Brattleboro Retreat*, the court extended the "zone of danger," requiring mental health professionals to anticipate injuries caused by their patients involving unidentified victims.[329] The case involved the release of a voluntarily hospitalized[330] and potentially dangerous patient, E.R., into the custody of his parents, arguably without sufficient instruction for them as they, as his "caregivers," would need to protect third persons against violence that might be committed by E.R.[331] His parents, who had monitored E.R. "closely" while he was a patient at the Vermont State Hospital

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[327] *Id.* at 340 (emphasis added).

[328] *Id.* at 739 ("The principles underlying the *Tarasoff* decision indicate that even the existence of an identifiable victim is not essential to the cause of action. Our decision rested upon the basic tenet of tort law that a 'defendant owes a duty of care to all persons who are *foreseeably* endangered by his conduct.'").

[329] Kuligoski v. Brattleboro Retreat & Ne. Kingdom Human Servs., 156 A.3d 436, 450–51 (Vt. 2016); *see* Rafik Sidaros & Kevin V. Trueblood, *Expansion of the Duty to Protect Includes Foreseeable Victims in the Zone of Danger*, 45 J. AM. ACAD. PSYCHIATRY & L. 111 (2017).

[330] The court noted that although the patient had been diagnosed as "dangerous" and warranting involuntary hospitalization, there was no evidence in the record that there had been any effort to proceed with commitment. *Kuligoski*, 156 A.3d at 441. The court explained: "We recognize that his status as a voluntary patient seems inconsistent with some of the later facts, including his attempt to escape from the Vermont State Hospital. Inconsistencies of this type are not unusual in a complaint." *Id.* at 441 n.2.

[331] *Id.* at 450 ("[S]everal other courts have held that a duty to warn is owed not only to specifically identified or identifiable victims, but to *foreseeable* victims or to those whose membership in a particular class—for example, those living with the patient—places them within a zone of danger.").

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and defendant *Brattleboro Retreat*,[332] assumed custody upon his release.[333] When they took him with them to an apartment building owned by his grandparents, he left them and went into the basement, where he assaulted the plaintiff, who was working on the building furnace at the time.[334]

The plaintiffs directed the underlying theme of their complaint to the failure of the treating mental health professionals to properly address their obligations to E.R.'s parents as his "caregivers."[335] The plaintiffs claimed the treating health professionals essentially failed to prepare E.R.'s parents to prevent injury to third persons by their son,[336] and specifically, in discharging E.R.[337] *Kuligoski v. Brattleboro Retreat* suggests the significant extent to which liability for mental health professionals can be predicated on logical streams of action that can be included within the notion of "foreseeability." The problem with imposing liability based upon relying on the *logic* of any particular set of events lies in requiring them to be anticipated rather than reconstructed in hindsight.

Moreover, the problem with expecting warnings or other protective action to prevent violence based on the training and experience of mental health professionals lies in the obvious fact that unless an individual with violent propensity is either in a therapeutic relationship or being examined pursuant to a court order or other outside source of authority, the opportunity to make a competent risk assessment is simply not available. The success of the warning, or duty to warn, is, thus, dependent on the situational scenario in which the mental health professional has access to the individual who exhibits a propensity or disposition for violence.

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[332] *Id.* at 442.

[333] *Id.*

[334] *Id.* The court related the forensic findings regarding E.R.'s mental state at the time of the assault:

> The forensic psychiatrist who evaluated E.R. at the request of the criminal court stated that the night before the offense E.R. had not slept well, awoke early that morning, was just "sitting and staring," and was paranoid that people were staring at him en route to the apartment. The psychiatrist believed that E.R. likely was in a "psychotic haze" at the time of the offense, having been "overcome by the symptoms of his condition to the degree where he acted while in a psychotic storm."

Id.

[335] *Id.* at 442–43.

[336] *Id.*

[337] *Id.* at 442.

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B. Common Scenarios Involving Dangerous Patients

There are at least four scenarios in which the imposition of liability for failure to warn or protect, under the appropriate circumstances, logically makes sense. These scenarios reflect more predictable violence than might otherwise be subject to evaluation because they fit more common patterns and likely have rational bases for the hostility that may erupt in acts of physical violence. With respect to those scenarios in which risk assessment and protective action might appear most appropriate, the ability to identify a specific or likely victim would be the basic key to the imposition of a duty to warn or protect. These scenarios, in which warnings or other corrective action may be necessary, likely arise because of the nature of the apparent relationship between the patient and any intended victim.

1. Scenarios Most Likely Warranting a Duty to Warn or Protect

Clearly, the optimal situation for the therapist who has determined that a patient's expressions of hostility pose a serious risk of metastasizing into physical violence will be one in which the patient has disclosed the intended victim or victims of a specific, credible threat. The post-*Tarasoff* history of judicial and legislative concern with the therapist's duty to address potential violence has focused significantly on the question of how far to extend a duty to warn when potential victims of patient violence have not been identified, or when threats are perceived as reflecting a serious risk of violence but are general in nature with no identification of victims who might be personally warned of the threat of violence.

a. Situations Involving Institutional Restraint of the Patient

One of the most difficult questions about *Tarasoff* liability involves the scope of foreseeability when the dangerous patient or other individual has already been restrained by emergency or involuntary civil commitment for diagnosis and treatment. Once a dangerous patient has been restrained through the civil commitment process generally recognized as constitutionally mandated by the Supreme Court in *Addington v. Texas*,[338] there is an explicit finding that the civil committee suffers from a mental disorder of some kind and represents a danger to himself or herself or to others.[339] But, the question of liability for violence committed

[338] 441 U.S. 418 (1979).

[339] *Id.* at 429. In *Addington*, the Court held that constitutionally required burden of proof to be applied in an involuntary civil commitment proceeding is one equivalent "clear and convincing evidence." *Id.* at 433. In ruling on this question of due process, the Court implicitly accepted the substantive requirements

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by a patient upon a third person may actually militate against the conclusion that, once released, the patient posed a threat requiring further action. The release itself serves to provide some evidence that mental health professionals have determined that the involuntarily committed patient no longer poses a threat to himself or others. But, as the Vermont decision in *Kuligoski v. Brattleboro Retreat* demonstrates,[340] the release of the dangerous patient may still result in liability, even if professional judgment has warranted discharge from confinement.

In *Leonard v. State of Iowa*,[341] the Iowa Supreme Court addressed the problem posed by the claim that the mental health professionals were negligent in failing to warn of the potential for violence committed by a patient when there was no identifiable victim of any threat made by the patient.[342] In *Tarasoff*, an important factor in the court's decision was that the therapists knew that Tatiana was Poddar's intended victim, so it was not unreasonable to expect that she be notified of his threats and permitted to take action to avoid injury.[343] In contrast, in *Leonard*, there was no indication that anyone had any reason to believe that the victim was personally threatened by the potentially violent patient, Parrish.[344]

Diagnosed with bipolar disorder, Parrish had been discharged from a mental health facility after reaching "maximum inpatient psychiatric benefits," according to the discharge summary.[345] He returned to work as a demolition contractor with directions to continue outpatient therapy and hired plaintiff Leonard to work for him.[346] Following a day when the two men spent their time drinking rather than

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for involuntary commitment: "Whether the individual is mentally ill and dangerous to either himself or others and is in need of confined therapy turns on the *meaning* of the facts which must be interpreted by expert psychiatrists and psychologists." *Id.* at 429 (emphasis in original). In *Foucha v. Louisiana*, the Court cited *Addington* in affirming the substantive issues that must be addressed in the involuntary civil commitment process: "[T]o commit an individual to a mental institution in a civil proceeding, the State is required by the Due Process Clause to prove by clear and convincing evidence the two statutory preconditions to commitment: that the person sought to be committed is mentally ill and that he requires hospitalization for his own welfare and protection of others." 504 U.S. 71, 75–76 (1992).

[340] 156 A.3d at 440–41.

[341] 491 N.W.2d 508, 508–09 (Iowa 1992).

[342] *Id.* at 510.

[343] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 345 (Cal. 1976).

[344] 491 N.W.2d at 511.

[345] *Id.* at 509–10.

[346] *Id.* at 510.

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working, they returned to Parrish's residence where Parrish subsequently beat Leonard severely about his head and body, leaving him unconscious and locked inside his house. Parrish was subsequently convicted of kidnapping and attempted murder.[347]

Leonard brought his action against the State and its mental health facility under the Iowa Tort Claims Act,[348] alleging negligence and specifically asserting that "the defendants failed to provide Parrish with proper care and treatment and that they subsequently discharged him knowing that he posed a threat to those with whom he might come in contact."[349] What Leonard was able to show was that Parrish had a lengthy history of psychiatric hospitalizations and criminal charges for minor but somewhat violent offenses. What he could not demonstrate was that the State and its mental health professional employees had a basis for knowing that he was an intended victim of Parrish. Nor could he demonstrate that he was injured under circumstances in which the therapists would have been unable to reasonably conclude that he was a potential victim of Parrish, as opposed to simply being assaulted only because he was with Parrish while his employer was intoxicated.[350]

The Iowa court's opinion never mentioned *Tarasoff* but clearly addressed the broader question of the scope of the mental health professional's duty to protect third persons from injuries committed by their patients. Acknowledging the existence of the special relationship that exists between therapists and patients, it framed the question as follows:

> There can be little doubt that a special relationship existed between Parrish and his treating physician at MHI. His continuing involuntary commitment only serves to reinforce that bond. Therefore MHI had a duty to control Parrish's conduct, or at least not negligently release him from custody. But the Restatement

[347] *Id.*

[348] IOWA CODE §§ 669.1–.25 (1993). Under the Act, individuals injured as a result of negligence on the part of a state employee may recover "under circumstances where the state, if a private person, would be liable to the claimant for such damage, loss, injury, or death." § 669.2(3)(a). In contrast, Arkansas does not provide a civil remedy for actions by the State or its officials or employees acting within the course of their official duties, insulating those potential defendants to civil liability pursuant to the constitutional doctrine of sovereign immunity. ARK. CONST. art. V, § 20; ARK. CODE ANN. § 19-10-305(a) (1993). Instead, a party injured by the State may proceed by filing a claim with the Arkansas Claims Commission. ARK. CODE ANN. §§ 19-10-201 to -216 (2019).

[349] *Leonard*, 491 N.W.2d at 510.

[350] *Id.* at 511.

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> rules cited above do not answer the precise question before us: Does the duty to refrain from negligently releasing dangerous persons from custody run from the custodian to the public at large or only to the reasonably foreseeable victims of the patient's dangerous tendencies?[351]

The Iowa court declined to adopt and apply *Tarasoff* in a later decision, *Estate of Long ex rel. Smith v. Broadlawns Medical Center*.[352] There, the claim for malpractice was predicated on the murder of a patient's wife after the patient, Gerald, was released from hospitalization necessitated by a complex diagnosis of disorders or symptoms, including post-traumatic stress disorder and polysubstance abuse, that initially included hallucinations and flashbacks.[353] The cause of action was actually based upon the failure of the institution to notify the patient's wife, Jillene, of his discharge so that she could leave the marital residence before he was able to confront her again.[354] He was discharged from Broadlawns to travel to a center for chemical dependency, but he left that facility and then "went to a local pawnshop, pawned his watch, and bought a bus ticket back to Des Moines. Gerald returned to the marital residence, perhaps to lie in wait for Jillene. When Jillene returned to the home that evening, Gerald shot her several times, killing her."[355]

The Iowa court again expressly declined to hold that *Tarasoff* would apply in this case: "We have not previously adopted the duty principles enunciated in *Tarasoff*

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[351] *Id.* (citing RESTATEMENT (SECOND) OF TORTS §§ 315, 319 (AM. LAW INST. 1965)). Both Restatement sections address the exceptions to the general common law rule that "a person has no duty to control the conduct of another." 491 N.W.2d at 511. Section 319 recognizes an exception to the general rule: "One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm." RESTATEMENT (SECOND) OF TORTS § 319 (AM. LAW INST. 1965). The court also noted the Restatement's illustration of this proposition, noting, "the liability of a hospital to a person infected by a diseased patient who is negligently released, and the liability of an insane asylum for injury caused by the negligent release of a homicidal maniac." 491 N.W.2d at 511 (citing RESTATEMENT (SECOND) OF TORTS § 319 cmt. a, illus. 1, 2 (AM. LAW INST. 1965)).

[352] 656 N.W.2d 71 (Iowa 2002), *abrogated by* Thompson v. Kacinski, 774 N.W.2d 829, 836 (Iowa 2009). The court in *Thompson* adopted a "foreseeability" analysis with a "risk" analysis test for liability applied by drafters of RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 7(a) (AM. LAW INST. 1996). 774 N.W.2d at 834–35.

[353] *Smith*, 656 N.W.2d at 77–78.

[354] *Id.* at 83.

[355] *Id.* at 78.

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and do not do so at this time."[356] Still, the court upheld the finding of negligence based on the failure to notify the patient's wife of his discharge. However, it found *Tarasoff* inapplicable because the "special relationship" underlying that decision existed between the patient and treating institution, whereas here the wife's death was attributable to the special relationship created by Broadlawns's promise to warn her of her husband's discharge, which was necessitated by her actual knowledge of her husband's propensity for violence.[357] Because Broadlawns failed to warn Jillene when Gerald was released, the substantial verdict based on this failure was upheld on appeal, even though the reviewing court declined the Estate's argument that *Tarasoff* applied.[358]

The *Leonard* court noted the divergent approaches taken by courts considering the issue of liability for patient violence committed upon third persons following discharge from civil commitment.[359] Some courts had addressed liability based on the duty to protect or warn by basically imposing liability on professionals for failure to protect or warn the public at large or classes of potential victims.[360] Other courts

[356] *Id.* at 80.

[357] *Id.* at 78.

[358] *Id.* at 80–81. Subsequently, in *Thompson v. Kaczinski*, 774 S.W.2d 829, 836 (Iowa 2009), the court retreated from its reliance on RESTATEMENT (SECOND) OF TORTS § 431 (AM. LAW INST. 1965), in which the actor's conduct is considered a legal cause of liability cause if is it a substantial factor in bringing about the result. Instead, it adopted the "risk standard" approach taken by the RESTATEMENT (THIRD) OF TORTS to address confusion often created in jurors' minds by the "proximate cause" test, quoting from the comment to the Restatement:

> Properly understood, both the risk standard and a foreseeability test exclude liability for harms that were sufficiently unforeseeable at the time of the actor's tortious conduct that they were not among the risks—potential harms—that made the actor negligent. . . . [W]hen scope of liability arises in a negligence case, the risks that make an actor negligent are limited to foreseeable ones, and the factfinder must determine whether the type of harm that occurred is among those reasonably foreseeable potential harms that made the actor's conduct negligent.

774 N.W.2d at 839 (quoting RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM § 29 cmt. d (AM. LAW INST. 1996)).

[359] Leonard v. Iowa, 431 N.W.2d 508, 511–12 (Iowa 1992).

[360] *See, e.g.*, Perreira v. State, 768 P.2d 1198, 1201 (Colo. 1989) (finding liability based on the negligent release of a violent patient who killed a police officer without a specific intended victim because the therapist still had a duty to assess a patient's propensity for violence and protect others by restraining the patient for a longer period); Naidu v. Laird, 539 A.2d 1064, 1072–73 (Del. 1984); Boulanger v. Pol, 900 P.2d 823 (Kan. 1995) (limiting Durflinger v. Artiles, 673 P.2d 82 (Kan. 1983) to finding liability based on the release of involuntarily committed mental hospital patients).

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had limited recovery based on the duty to warn of patient violence that could reasonably be anticipated by the treating therapist.[361] The *Leonard* court noted that other jurisdictions imposed liability only for injuries sustained by third persons specifically identified in patient threats.[362]

On the facts presented, specifically the lack of any knowledge that Leonard would be victimized by Parrish, the Iowa court in *Leonard* rejected the argument that liability for the patient's violence should extend to the public generally.[363] The court reasoned that "the risks to the general public posed by the negligent release of dangerous mental patients would be far outweighed by the disservice to the general public if treating physicians were subject to civil liability for discharge decisions."[364]

Regardless of the approach taken by any individual jurisdiction with respect to the imposition of a duty to warn third persons of potential patient violence, the circumstances in which the involuntarily committed patient is released provide a compelling factual scenario in which the decision to release without warning may give rise to a claim of negligence resting on a breach of the mental health professional's duty to protect third persons from patient violence. Quite apart from whether such a duty is imposed in a jurisdiction, civil recovery is likely to be difficult because of the operation of statutory immunity protections that are designed to facilitate professional use of the involuntary civil commitment process to deal with potentially violent, impaired persons.[365]

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[361] *See, e.g.*, Hamman v. Cty. of Maricopa, 775 P.2d 1122, 1127–28 (Ariz. 1995) (applying *Tarasoff* where a therapist could have reasonably identified the violent patient's family as the most likely potential victims, warranting liability even if no specific threat against the identifiable target was disclosed); Petersen v. State, 671 P.2d 230, 237 (Wash. 1983) (finding liability based on the release of a patient who had previously demonstrated dangerousness by driving while intoxicated after being released overnight and the danger was known to the patient's therapist who should have foreseen danger to others).

[362] *Leonard*, 491 N.W.2d at 511 (citing Furr v. Spring Grove Hospital, 454 A.2d 414, 420–21 (Md. Ct. Spec. App. 1983)) (following *Tarasoff* and strictly limiting recovery to situation involving known victim disclosed to therapist); McIntosh v. Milano, 403 A.2d 500, 511–12 (N.J. Super. Ct. Law Div. 1979) (discussing *Tarasoff* and finding liability where specific victim identified in patient's threat disclosed to therapist).

[363] *Leonard*, 431 N.W.2d at 512.

[364] *Id.* (citing Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983)).

[365] *See, e.g.*, ARK. CODE ANN. § 20-47-227 (2020) ("No officer, physician, or other person shall be held civilly liable for his or her actions pursuant to this subchapter in the absence of proof of bad faith, malice, or gross negligence.").

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b. Hostility Based on Failed Family or Interpersonal Relationships

Both *Tarasoff* and *Jablonski* arose in the context of failed familial or romantic relationships in which the patient's perceived hostility was directed toward obvious victims of his anger.[366] In both cases, the treating therapists considered the patient potentially violent, with the University psychologist in *Tarasoff* taking affirmative steps to have campus police restrain Poddar for purposes of hospitalization,[367] while the treating professionals in *Jablonski* did not conclude that hospitalization was warranted despite the patient's "explosive" behavior.[368]

Individual acts of patient violence are most likely to arise when there has been a history of actual violence toward an identified victim, such as a family member or individual who is involved with the patient in an intimate or otherwise extremely close interpersonal relationship, or when the relationship itself has collapsed. The actualization of violent intent might result either from the continued close proximity to the individual or others who are identified by the patient as a cause of their extreme anxiety, or from undesired estrangement. The scenarios suggested by this type of situation are ubiquitous in popular culture, moreover, and could hardly escape exposure to any but the most isolated of patients.

Mass shootings or other acts of mass violence may arise from these types of relationships, occurring in the context of family relationships.[369] Sometimes these

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[366] Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334, 341 (Cal. 1976); Jablonski v. United States, 712 F.2d 391, 392–93 (9th Cir. 1983).

[367] *Tarasoff*, 551 P.2d at 339–40.

[368] *Jablonski*, 712 F.2d at 394 ("Although Hazle believed that Jablonski was dangerous and that his case was an 'emergency,' both doctors concluded that there was no basis for involuntary hospitalization.").

[369] *See, e.g.*, *Sheriff Reconstructs the Murders of 16*, N.Y. TIMES (Jan. 1, 1988), http://www.nytimes.com/1988/01/01/us/sheriff-reconstructs-the-murders-of-16.html. The story relates the mass murder of his family by Ronald Gene Simmons in Russellville, Arkansas:

> Mr. Simmons, 47 years old, is accused of killing 14 relatives and two other people in a rampage that the authorities say began at his home in Dover before Christmas and ended in a 45-minute shooting spree in downtown Russellville. Mr. Simmons was formally charged Wednesday with two counts of capital murder and four of attempted murder.

Id. Simmons accepted the death sentence imposed by the capital jury and successfully waived his right to appeal. Simmons v. State, 766 S.W.2d 422, 422–23 (Ark. 1989). The case reached the United States Supreme Court when another death row inmate sought to intervene on Simmons' behalf as next friend to force the state supreme court to order appellate review to determine the validity of the death sentence, eventually losing. Whitmore v. Arkansas, 495 U.S. 149, 151–52 (1990).

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will include a patient's disclosure of a desire to injure, kill, or threaten one or more members of their immediate family.[370] Therapists may be able to identify potential victims more readily in these circumstances, suggesting that warnings to the patient or law enforcement would at least be more accurate, if not more effective, because of the likelihood of correct identification of a potential victim. But that does not mean that subsequent action by the patient, or warned victim, will prevent the tragedy, as the facts in *Jablonski* demonstrate.[371] Potential victims who have been involved in longer-term or more intense relationships with troubled patients may reject warnings altogether or minimize their import based on a failed perception of the seriousness of the threat of violence.

No contact orders issued by courts may, in a very real sense, serve to deter only those dangerous patients whose potential for aggression would otherwise be controlled; for the out-of-control violent patient, a judge's signed order may afford little protection, and may actually serve to antagonize the individual subject to the order further, sometimes contributing to violent retaliation.[372]

[370] *See, e.g.*, Hamman v. Cty. of Maricopa, 775 P.2d 1122, 1127–28 (Ariz. 1995) (applying *Tarasoff* where a therapist could have reasonably identified the violent patient's family as the most likely potential victims, warranting liability even if no specific threat against the identifiable target was disclosed); Petersen v. State, 671 P.2d 230, 237(Wash. 1983).

[371] *Jablonski*, 712 F.2d at 393 ("In a private conference following the diagnostic interview, Kimball told Kopiloff that she felt insecure around Jablonski and was concerned about his unusual behavior. Kopiloff recommended that she leave Jablonski at least while he was being evaluated. When Kimball responded 'I love him,' Kopiloff did not warn her further because he believed she would not listen to him.").

[372] *See* Brian H. Spitzberg, *The Tactical Topography of Stalking Victimization and Management*, 3 TRAUMA, VIOLENCE & ABUSE 261–88 (2002), http://journals.sagepub.com/doi/pdf/10.1177/1524838002237330 ("A summary of 32 studies of restraining orders indicated that they are violated an average of 40% of the time and are perceived as followed by worse events almost 21% of the time."). The author is Senate Distinguished Professor of Communication at San Diego State University. *Dr. Brian Spitzberg*, SDSU SCH. OF COMMC'N, https://communication.sdsu.edu/faculty_and_staff/profile/dr.-brian-h.-spitzberg (last visited June 6, 2021).

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c. Workplace or Employment-Related Violence

Mass shootings have occurred[373] when disgruntled employees or employees who have been terminated later opened fire at their current or former workplace,[374] sometimes referred to as "going postal."[375] Just over a week after a fatal shooting at an ex-employee's workplace in Orlando on June 5, 2017,[376] there was another workplace shooting at a UPS office in San Francisco.[377] These scenarios are perhaps most likely to result in identifiable targets for violence in a workplace venue when employment issues are causing the patient intense anxiety. For instance, seven people were killed, and twenty-five others injured, in a shooting in Odessa and Midland, Texas, in 2019; the shooter had been fired from his job hours earlier and began the rampage through the cities after being stopped for a routine traffic violation.[378]

But, other mass shootings may be perpetrated as a result of retaliation by mentally unstable individuals who did not have a previous employment connection with a specific enterprise. Because of a known history of antagonism toward the

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[373] For a comprehensive list of workplace shootings, see *Number of Victims of Workplace Shootings in the United States Between 1982 and February 2020*, STATISTA, https://www.statista.com/statistics/476400/workplace-shootings-in-the-us-by-victim-count/ (last visited June 6, 2021).

[374] *See, e.g.*, Randal C. Archibold, *Ex-Employee Kills 5 Others and Herself at California Postal Plant*, N.Y. TIMES (Feb. 1, 2006), http://www.nytimes.com/2006/02/01/us/health/exemployee-kills-5-others-and-herself-at-california-postal-plant.html. The reporter wrote:

> A woman who had left her Postal Service job because of psychological problems shot and killed five former colleagues and critically wounded another at a sorting plant here Monday night before fatally shooting herself, the authorities said Tuesday. . . . The violence provided a flashback to the spate of shootings at post offices and related facilities in the 1980's and 90's. The last such shooting was eight years ago in Dallas, when a letter carrier killed a clerk after arguing in a break room. The deadliest was the August 1986 killings of 14 people by a co-worker in Edmond, Okla., who then killed himself.

Id.

[375] The term "going postal" is attributed to Karl Vick who noted the United States Postal Service's use of the phrase in response to mass shootings:

> The symposium was sponsored by the U.S. Postal Service, which has seen so many outbursts that in some circles excessive stress is known as "going postal." Thirty-five people have been killed in 11 post office shootings since 1983. The USPS does not approve of the term "going postal" and has made attempts to stop people from using the saying. Some postal workers, however, feel it has earned its place.

Karl Vick, *Violence at Work Tied to Loss of Esteem*, ST. PETERSBURG TIMES (Dec. 17, 1993).

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enterprise, it could be that threats of violence would explain the context in which the mass shooting occurs. In some instances, expressions of violence by the individual could provide some basis for deterrence, although not necessarily by a *Tarasoff* warning because the perpetrator may not have been involved in mental health treatment at the time.

For instance, the shooter's motivation for killing five employees of the Annapolis, Maryland *Capital Gazette* newspaper was that he claimed the paper mistreated him in its stories related to his conviction for harassing a former high school classmate.[379] The shooter had filed a libel suit against the newspaper, which published a chain of papers in the Eastern Shore, and "waged a social media campaign" against the *Gazette*.[380] On the morning of the rampage, June 28, 2018, the shooter sent a letter to the Gazette's lawyer, "announcing that he planned to go there 'with the objective of killing every person present,' a copy of the letter shows."[381] Here, the shooter's motivation was apparently known—generally and to the

[376] *See* Les Neuhaus, Lindsey Bever & Mark Berman, *'Disgruntled' Ex-employee Fatally Shot Five at Orlando Business, Then Killed Himself, Police Say*, WASH. POST (June 5, 2017), https://www.washingtonpost.com/news/post-nation/wp/2017/06/05/multiple-people-killed-in-shooting-at-florida-business/?utm_term=.e12b4466277b. The perpetrator was a military veteran with a minor criminal record. *Id.*

[377] *See* Eliott C. McLaughlin & Dan Simon, *Officials Identify Gunman, Victims in UPS Shooting*, CNN (June 15, 2017), http://www.cnn.com/2017/06/14/us/san-francisco-shooting/index.html. A gunman wearing a UPS uniform shot five UPS employees, killing three, before fatally shooting himself at a UPS facility in San Francisco. *Id.*

[378] Allison Aubrey, *Texas Gunman Who Killed 7 Had Been Fired Just Hours Before Shootings*, NPR (Sept. 2, 2019), https://www.npr.org/2019/09/02/756772750/texas-gunman-who-killed-7-had-been-fired-just-hours-before-shootings-reports. The total number of deaths increased to 25 as other victims died later. *See Police Raised Concerns About West Texas Gunman 8 Years Before Shooting in Odessa*, EL PASO TIMES (Sept. 29, 2019), https://www.elpasotimes.com/story/news/texasregion/2019/09/29/police-raised-concerns-odessa-texas-shooting-gunman-8-years-ago/3815002002/.

[379] *See* Matt Stevens & Daniel Victor, *Annapolis Shooting Suspect Wanted to 'Kill Every Person' in Newsroom, Letter States*, N.Y. TIMES (July 2, 2018), https://www.nytimes.com/2018/07/02/us/annapolis-shooting-woman-harassed.html.

[380] *See* Sabrina Tavernise, Amy Harmon & Maya Salam, *5 People Dead in Shooting At Maryland's Capital Gazette Newsroom*, N.Y. TIMES (July 18, 2018), https://www.nytimes.com/2018/06/28/us/capital-gazette-annapolis-shooting.html (accessed Feb. 2, 2020) ("The article was published in July 2011 with the headline 'Jarrod Wants to Be Your Friend,' and detailed a harassment charge against Mr. Ramos. According to the article, Mr. Ramos sent a friend request on Facebook to a former high school classmate and over the course of several months, he 'alternately asked for help, called her vulgar names and told her to kill herself.'").

[381] *See* Stevens & Victor, *supra*, note 379.

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victims—yet it could be that the ultimate act of violence was simply not anticipated by the news organization, which likely had been subjected to threats for its treatment of other news in the past. Nevertheless, there was a basis for recognizing the potential danger:

> Thursday's shooting prompted law enforcement officials throughout the country to protect media organizations. As the day proceeded, however, investigators were looking into whether the attack was an isolated grudge.
>
> "Jarrod Ramos has a long history of being angry and taking action against The Capital newspaper," said Tom Marquardt, a former executive editor and publisher at The Capital. "I said at one time to my attorneys that this was a guy that was going to come and shoot us. I was concerned on my behalf and on behalf of my staff that he was going to take more than legal action."[382]

Even when there is a clear workplace connection between the shooter and victims, most evident when the shooting occurs at the workplace, the shooter's state of mind or motivation may not be discernible. For example, the fatal shooting of twelve of the shooter's former co-workers, and the injury of four more, has withstood investigation into the motivation of the civil engineer who had recently resigned from his position with the city of Virginia Beach, Virginia.[383] There was no known evidence of mental illness, nor any indication of the reason for his resignation, having resigned in good standing.[384] With no apparent grievance against the city or fellow employees and no known history of mental illness or emotional crisis, the motivation

[382] Tavernise et al., *supra* note 380.

[383] *See* Sara Gregory, Jane Harper & Alissa Skelton, *13 Dead, Including Gunman, in Shooting At Virginia Beach Municipal Center*, VIRGINIAN-PILOT (May 31, 2019, 10:15 AM), https://www.pilotonline.com/news/virginia-beach-mass-shooting/article_777b737e-83e3-11e9-b1d0-dff7ad725d5e.html. The shooting occurred on May 31, 2019. *Id.*

[384] *See* Michael E. Miller, Lynh Bui & Julie Zauzmer, *DeWayne Craddock, a Longtime Virginia Beach Employee, Identified as Shooter Who Killed 12 in City Building*, WASH. POST (June 1, 2019, 8:03 PM), https://www.washingtonpost.com/local/public-safety/dewayne-craddock-a-longtime-virginia-beach-employee-identified-as-shooter-who-killed-12-in-city-building/2019/06/01/0fe20766-840e-11e9-95a9-e2c830afe24f_story.html; *see also* Michael E. Miller, Ian Shapira & Julie Zauzmer, *Virginia Beach Mass Shooter Reveals Little in Resignation Note Sent Day of Massacre*, WASH. POST (June 3, 2019), https://www.washingtonpost.com/local/public-safety/we-lean-on-each-other-some-virginia-beach-employees-share-prayer-embraces-as-they-return-to-work/2019/06/03/a39fb228-8607-11e9-a491-25df61c78dc4_story.html.

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for this shooting remains an unsolved mystery disturbing the community a year later.[385]

The problem posed by workplace shootings in terms of assessing a perpetrator's motive is that unless the circumstances of their work relationship or termination are already disclosed, it may be that an actual motive will never be disclosed if the shooter dies in the assault. In some cases, explanations or even ramblings posted on social media may, of course, provide a strong basis for drawing inferences from the shooter's words and circumstances of the mass assault that would be accurate. Unless disclosed to a mental health professional in the course of mental examination or evaluation, or treatment for a diagnosis manifested by threats of violence, *Tarasoff* offers little hope for the prevention of an episode of mass violence by warning or other action, such as emergency hospitalization.

d. School Shootings by Current or Former Students

Experience with episodes of mass violence may inform mental health professionals of a range of potential acts that could logically follow disclosure of patient propensity for violence, even when those acts might be viewed as unprecedented. The recent history of mass shootings at schools committed by juveniles serves to inform therapists of the potential for mass violence committed by emotionally disturbed children, particularly when there are firearms accessible to them. One early example of this scenario occurred in Jonesboro, Arkansas, in 1998, when two boys, aged 13 and 11, opened fire on schoolchildren with weapons taken from the younger child's home, including three semi-automatic rifles and ten other loaded weapons.[386] The circumstances of the assault, which left four students and one teacher dead and ten other children wounded, included this shocking evidence of their planning: "both of the boys had been raised around guns. They belonged to gun clubs and even participated in practical shooting competitions, which involve

[385] Although law enforcement had promised a complete report on the shooter's motivation, *The Virginian-Pilot*, the newspaper in Hampton Roads, Virginia, complained editorially a year later that no investigation had been fully shared with the community. *See Editorial: Public Needs Full Account of Virginia Beach Shooting*, VIRGINIAN-PILOT (May 5, 2020), https://www.pilotonline.com/opinion/vp-ed-editorial-beach-shooting-report-0505-20200505-yyzttwqidramhkzsl7ef3o3yya-story.html.

[386] *March 24, 1998: A School Shooting in Joneboro, Arkansas Kills Five*, HISTORY: THIS DAY IN HISTORY (Nov. 13, 2009), http://www.history.com/this-day-in-history/a-school-shooting-in-jonesboro-arkansas-kills-five.

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firing at simulated moving human targets. Golden reportedly shot several dogs in preparation for the actual shooting."[387]

An ABC News report from February 12, 2016, included the following tabulation recording the history of school shootings from the date of the mass shooting at Columbine High School in Colorado in 1999:

> The numbers that follow are a part of a larger conversation about school violence and children in crisis:
>
> **50**—The number of mass murders or attempted mass murders at a school since Columbine. (FBI records)
> **141**—The number of people killed in a mass murder or attempted mass murder at a school since Columbine. (FBI records)
> **73**—The percentage of school shooters with no prior criminal record, not even an arrest. (U.S. Secret Service, U.S. Department of Education)
> **96**—The percentage of school shooters who are male. (FBI records)
> **17**—The number of kids aged 15 or younger who have committed or attempted a mass school shooting since Columbine. (FBI records)
> **81**—The percentage of school shootings where someone had information that the attacker was thinking about or planning the shooting. (U.S. Secret Service, U.S. Department of Education)
> **68**—The percentage of school shooters who got their guns from relatives or at home. (U.S. Secret Service, U.S. Department of Education)
> **65**—The number of school shooters and thwarted school shooters who have referenced Columbine as a motivation. (ABC News investigation, various law enforcement agencies)

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[387] *Id.* Because the two juvenile shooters could not be prosecuted as adults under Arkansas law, they were subsequently released from custody after attaining the age of twenty-one; they are reportedly the only mass shooters living free at this time. *See* Meaghan Keneally, *The Only Two Living US Mass School Shooters Who Are Not Incarcerated*, ABC NEWS (Feb. 17, 2016), http://abcnews.go.com/US/living-us-mass-school-shooters-incarcerated/story?id=36986507. The ABC news follow-up story on the Westside school shooting reported:

> Adam Lanza killed himself. So did Seung-Hui Cho at Virginia Tech. And so did Eric Harris and Dylan Klebold in Columbine. And Christopher Harper-Mercer in Roseburg. And Elliot Rodger in Isla Vista.
> If you go down the list of mass shootings at U.S. schools, most of the killers turned the guns on themselves after killing classmates and teachers. Several others were killed by police, and a few were taken into custody alive.
> But only two are now out of prison, one of whom was arrested with a gun after his release, while the other has since applied for a concealed carry permit.

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> **270**—The number of shootings of any kind at a school since Columbine. (ABC News review of reported cases)
> **1**—The number of shootings per week, on average, on a school or college campus in 2015. (ABC News review of reported cases)[388]

School shootings have perhaps been the most troubling scenarios of mass violence in the United States because of the perception that schools should afford the greatest protection of public venues. This may be, in part, because of the vulnerability of children and younger persons, and in part because schools and colleges are often viewed as isolated from more common places in which conflict would escalate into deadly violence. The reality has been that schools are actually rather common forums for random violence or targeted violence that expands to include random victims beyond those intended victims who might be identified, at least in hindsight, because they have engaged in bullying or been bullied.

e. Thoughts on Common Circumstances, Venues

In each of the general circumstances discussed surrounding mass shootings, the unique character of the possible relationship between the perpetrator and victims suggests a basis for anticipating violence. This assumes that the duty to warn or prevent violence for mental health professionals can be predicated on either an actual threat by a patient during treatment or individual exhibiting thinking and tendencies to commit random acts of violence that could reasonably be evaluated in terms of the nature of the threat, intended victim, and likelihood that the individual would have sufficient resources, such as access to firearms, to act upon the expressed threat.

Logically, the circumstances discussed in the preceding paragraphs in Sections VI.B.1.a–d of this Article offer the most likely scenarios in which a treating professional would have the information supporting a conclusion warranting a warning to third persons targeted by the threats or to law enforcement. A patient already confined in a mental institution or in treatment who discloses violent thoughts toward family members, or individuals previously involved with another who displays extreme hostility, would be most likely to have disclosed sufficient information and intent to give rise to the treating professional's duty to warn or take steps designed to protect third persons, whether identified specifically or otherwise likely to be victims of random violence.

Workplace and school shootings also suggest the possibility of identifying potential violent actors based on a prior relationship between a former, terminated,

[388] Lauren Pearle, *School Shootings by the Numbers since Columbine*, ABC NEWS (Feb. 12, 2016), http://abcnews.go.com/US/school-shootings-columbine-numbers/story?id=36833245.

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or dissatisfied worker or student and the venue for an attack. In some instances, the individual expressing hostility to the workplace or school may have been treated by a mental health professional and disclosed animosity threatening violence during the course of examination or treatment. In those instances, the duty to warn or attempt to protect third persons from the patient's potential for violence may arise as a result of the disclosure and professional's assessment of the patient's ability to carry out a special or general threat. Otherwise, it would seem unlikely that mental health professionals would have particularized knowledge that would trigger a duty to warn, although mental health professionals may often have significant information aiding employers, school officials and teachers, and law enforcement in determining the probability that a disaffected individual may pose a threat to others. This kind of knowledge may warrant ongoing evaluation of the individual's continued hostility and ability to carry through on a disclosed threat or access to weapons that could be used in an attack.

2. Less Common or Unexpected Scenarios and Warnings

Although certain scenarios in which acts of mass violence occur are either common or seem relatively predictable, they may still remain troubling in terms of identifying situations or circumstances regarding *specific* victims when mass shootings occur at schools, theaters, shopping malls, and other public venues where the targeting of victims appears random. In these situations, even if the perpetrator has engaged in therapeutic sessions with mental health professionals, they may not have disclosed specific targets of hostility or plans for attacks. There may well have been such insufficient indication of a planned or spontaneous attack that there could have been no preventive action taken based on a reasoned assessment of generalized threats.

In contrast to situations in which attacks of mass violence appear to be related to a particular activity or circumstance, other considerations minimize any expectation that the violence could reasonably be anticipated and prevented by warnings by mental health professionals. Venues may suggest commonality in terms of predictability, but in fact, contexts still vary in terms of important facts that compromise the prospect for prevention. Throughout the recent national history of mass shootings, venues in which these attacks occur do not reflect the degree of commonality that may characterize the circumstances or motivation of shooters permitting generalized conclusions.

a. Religious Venues

A prior relationship between the perpetrator of the act of mass shootings and prospective victims or the venue in which the violence occurs would logically appear to offer the best chances for prevention of shootings or other acts occurring in houses of worship. The personal history of the perpetrator and the religious group involved would suggest a sound opportunity for application of the mental health professional's

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duty to warn prospective victims or act to protect third persons from injury. It does not mean, of course, that threats made to a congregation or members of a specific religious communities will necessarily be disclosed to professionals positioned to evaluate the seriousness of threats or trained to take appropriate action; thus, the opportunity for prevention may not arise. Moreover, recent history demonstrates that violent assaults against worshippers have not been traced to internal sources, or prior relationships, but from external sources; although precise determination of motivation is often simply not available for that reason.

In the mass shooting committed during a service conducted in Milwaukee in 2005 by the Living Church of God, the shooter, Terry Ratzmann, was a disaffected church member.[389] He shot and killed four other members including the church's pastor,[390] and wounded seven others before turning his weapon on himself, with three of the others dying later.[391] He had reportedly been suffering from depression prior to the shooting, according to another church member.[392]

Investigation into the shooter's motivation focused on the shooter's relationship with the church:

> "We believe that the motive has something to do with the church and the church services more so than any other possible motive," Capt. Phil Horter of the Brookfield, Wis., Police Department said at a news conference on Monday. "We're looking at the church totality, whether it's members of the church, members of the hierarchy of the church, the sermons of the church," he added.
>
> *Investigators are combing through some 1,000 e-mail messages and other files, about 70 of them encrypted, on three computers seized from the home where*

[389] *See* Aamer Madhani & Tom Rybarczyk, *Gunman Kills 7 in Rampage*, CHI. TRIB. (Mar. 13, 2005), https://www.chicagotribune.com/news/ct-xpm-2005-03-13-0503130385-story.html. The shooting occurred at a service conducted at a suburban Milwaukee Sheraton Hotel, where the congregation had met for several years, committed by a long-time member of the fundamentalist, Adventist-like sect adhering to Old Testament, retaining Jewish festivals and observing the Sabbath on Saturday. *Id.*

[390] *Church, Police Probe 7 Murders*, CBS NEWS (Mar. 14, 2005), https://www.cbsnews.com/news/church-police-probe-7-murders/.

[391] Madhani & Rybarczyk, *supra* note 389.

[392] *Id.*

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> *Mr. Ratzmann lived with his mother and sister, and one from his office.* A message left on the Ratzmanns' answering machine on Monday was not returned.[393]

The Living Church of God mass shooting could reasonably have been explained as rooted in the shooter's prior relationship with the church or its membership, doctrine, or practice based on information available to law enforcement, including the report that he had suffered from depression prior to the episode.[394] The investigation into this mass shooting also revealed an important investigative tool available in other attacks targeted at religion, religious institutions, or religious services, apart from witness interviews. It reflects the importance of access to information and opinions posted on personal computers and internet sites by individuals in advance of carrying out planned acts of mass violence.[395]

In contrast to the Living Church of God mass shooting, more recent episodes involving venues of religious worship have not commonly involved disaffected members of the same religious community as victims. In fact, in many instances of mass violence directed at worship or worship places, the probable motive for the attack is external. For instance, threats against Islamic mosques are reportedly on the rise,[396] and groups misidentified with Islam have been targeted, such as the attack on a Sikh temple in Wisconsin in 2012, as reported by the *New York Times*:

> "Everyone here is thinking this is a hate crime for sure," said Manjit Singh, who goes to a different temple in the region. *"People think we are Muslims."*

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[393] Jodi Wilgoren, *Police Focus on Religion in Milwaukee Shootings*, N.Y. TIMES (Mar. 15, 2005), https://www.nytimes.com/2005/03/15/us/police-focus-on-religion-in-milwaukee-shootings.html (emphasis added).

[394] *Id.*

[395] *See, e.g.*, *Church, Police Probe 7 Murders*, CBS NEWS (Mar. 24, 2005, 1:44 AM), https://www.cbsnews.com/news/church-police-probe-7-murders/ ("The Milwaukee Journal Sentinel reported Monday the Feb. 26 sermon that upset Ratzmann had made the point that people's problems are of their own making. According to the paper, police trying to piece together a motive for the rampage are studying encrypted files from Ratzmann's three computers, seized from the home he shared with his mother and sister in New Berlin, Wisconsin.").

[396] *Nationwide Anti-Mosque Activity*, ACLU, https://www.aclu.org/issues/national-security/discriminatory-profiling/nationwide-anti-mosque-activity (last updated May 2021) (last visited June 6, 2021) ("In recent years, anti-Muslim sentiment has spiked. Although these sentiments manifest themselves in many ways, attacks on mosques directly take aim at religious freedom. Existing and proposed mosque sites across the country have been targeted for vandalism and other criminal acts, and there have been efforts to block or deny necessary zoning permits for the construction and expansion of other facilities.").

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> Though violence against Sikhs in Wisconsin was unheard of before the shooting, many in this community said they had sensed a rise in antipathy since the attacks on Sept. 11 and suspected it was because people mistake them for Muslims. Followers of Sikhism, or Gurmat, a monotheistic faith founded in the 15th century in South Asia, typically do not cut their hair, and men often wear colorful turbans and refrain from cutting their beards.[397]

The link between shootings at mosques and prejudice directed at Islam among all ethnic populations adhering to Islamic theology has been clearly confirmed in the rampage in which forty-nine were killed and forty injured in mass shootings at two mosques in New Zealand in March 2019.[398] The shooter's intent was apparently disclosed prior to the action in which three individuals were arrested:

> Before the attacks that took place during Friday prayers at about 1.40pm local time, the gunman reportedly published a racist manifesto on Twitter. He then live-streamed his rampage, according to an analysis by *Agence France-Presse*.
>
> Video footage, widely circulated on social media, showed a gunman randomly shooting at people inside a mosque while worshippers, possibly dead or wounded, lay huddled on the floor.[399]

The New Zealand attack apparently prompted a so-called *copy-cat* act of mass violence. Within a few days of the New Zealand attack, a San Diego college student set fire to a mosque in Escondido, California, in which seven worshippers escaped injury; then a month later, the student opened fire on a Passover service at a Jewish synagogue, killing one and injuring three other worshippers, including the Rabbi.[400] The San Diego perpetrator was apparently motivated by his interest in the live-streaming of the New Zealand mass shooting, which he reportedly found unsatisfying because he was not able to view the episode: "complaining none of the

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[397] Steven Yaccino, Michael Schwirtz & Marc Santora, *Gunnman Kills 6 At a Sikh Temple Near Milwaukee*, N.Y. TIMES (Aug. 5, 2012), https://www.nytimes.com/2012/08/06/us/shooting-reported-at-temple-in-wisconsin.html (emphasis added).

[398] John Power & Gigi Choy, *New Zealand Shooting: 49 Killed, More Than 40 Wounded in Mass Shootings At Christchurch Mosques*, S. CHINA MORNING POST (Mar. 15, 2019), https://www.scmp.com/news/asia/australasia/article/3001786/schools-shut-down-people-warned-stay-home-after-serious.

[399] *Id.*

[400] Julie Watson & Elliot Spaga, *Warrants Say New Zealand Attack Inspired Synagogue Shooting*, ASSOCIATED PRESS (July 13, 2019), https://apnews.com/7efa7c16be6d4b82b110e44104f26f80.

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links to the live-streamed video of the massacre were working and added, 'I could've seen it live damnit,' according to the search warrants."[401]

The combination of religious hatred and improvised visual depiction of violence reflected in the San Diego incidents suggests the significant attraction of some perpetrators in the representation or publication of their actions, evidence of deviance perhaps beyond the scope of published manifestos or rants. Attacks on mosques likely reflect a combined source of hostility based on religion and ethnic bias directed at those ethnically diverse groups that embrace Islam in significant numbers. After the September 11, 2001 attack on the World Trade Center, anti-Islam attacks may reflect coalescing of these various sources of potential animosity with national responses to Middle Eastern populations.

Similarly, there is evidence that the combination of ethnic and religious bias common to Anti-Semitism spawned the number of attacks against synagogues, including the mass shooting at the Tree of Life Congregation in Pittsburgh on October 27, 2018, the deadliest shooting at a Jewish synagogue in U.S. History.[402] During the shooting, eleven worshippers, many elderly, were killed and four of six victims wounded were police officers.[403] The shooter's motivation was apparently based on the fact that his primary victims were Jewish. "During the shooting, 'Bowers made statements regarding genocide, and his desire to kill Jewish people. After a standoff with police, Bowers eventually surrendered, and remains in federal custody today.'"[404]

To the extent that mass violence is directed at Jewish synagogues or individuals, the existence of Anti-Semitism as the basis of an attack does not suggest that intervention by mental health providers would be a likely means for preventing

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[401] *Id.* The *Associated Press* also reported that the perpetrator referenced the manifesto published by the New Zealand shooter, noting, "On March 20, investigators in the search documents said he sent another text about the writings saying, 'I think it's important that everyone should read it.'" *Id.*

[402] Campbell Robertson, Christopher Mele & Sabrina Tavernise, *11 Killed in Synagogue Massacre; Suspect Charged with 29 Counts*, N.Y. TIMES (Oct. 27, 2018), https://www.nytimes.com/2018/10/27/us/active-shooter-pittsburgh-synagogue-shooting.html. On April 13, 2014, an individual self-identified as Fraiser Glenn Cross, Jr. reportedly a former Grand Dragon of the Carolina Knights of the Ku Klux Klan, Frasier Glenn Miller, opened fire on a Jewish Community Center in Overland Park, Kansas, a Kansas City suburb, killing three persons. Gillian Mohney & Dean Scrabner, *Kansas Jewish Center Shooting Suspect Identified as Former KKK Leader*, ABC NEWS (Apr. 13, 2014), http://abcnews.go.com/US/kansas-jewish-center-shooting-suspect-identified-kkk-leader/story?id=23310932.

[403] Robertson et al., *supra* note 402.

[404] Shannon Van Sant, *Pittsburgh Synagogue Shooting Victims Identified*, NPR (Oct. 28, 2018), https://www.npr.org/2018/10/28/661530860/pittsburgh-synagogue-shooting-victims-identified.

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the assault. Unless the perpetrator has disclosed an intended act of violence or the intent to attack an individual, a treating mental health professional could not likely make the necessary determination that violence to third persons was intended simply from a patient's general hostility toward Jews or Israel.

Perhaps in contrast to mass shootings involving Islam and Jewish worship centers, or directed at Muslims or Jews individually or personally, the recent history of mass shootings involving Christian churches does not suggest so clearly an anti-Christian motivation. Instead, two episodes reflect that perpetrators may have chosen churches as the venue for shootings based on racial animosity. In the Charleston, South Carolina murder of nine worshippers at an African Episcopal Methodist Church in 2015, for instance, Dylann Roof's racist motivation was apparent both at the time of the shootings and later, during his trial when his confession was read to the jury.[405]

Another episode followed in Nashville when the shooter, an African American, attacked a church, killing one and injuring seven others in apparent retaliation for the mass killings at the Charleston church based on a written note.[406] The shooter was diagnosed as suffering from a mental illness, schizoaffective disorder, and likely post-traumatic stress disorder, but an examining psychiatrist concluded that the illness did not render him insane under state law.[407] The expert, however, concluded that there was no evidence of racial animus in the defendant's history, suggesting that the explanation given in the note was seemingly an aberration. Defense counsel stressed that the former member of the church had been described as "'polite, kind, and helpful,' in earlier years."[408]

The most violent church-based shooting in terms of casualties, which occurred at the First Baptist Church in Sutherland Springs, Texas, on November 5, 2017, displayed indicators of an episode either triggered by or possibly related to the assailant's history of mental impairment.[409] The shooter, Devin Kelly, had a

[405] Ford & Chandler, *supra* note 43; *see also* Keith O'Shea, Darran Simon & Holly Yan, *Dylann Roof's Racist Rants Read in Court*, CNN (Dec. 14, 2016), https://www.cnn.com/2016/12/13/us/dylann-roof-murder-trial/index.html.

[406] Travis Loller, *Tennessee Church Shooter Sentenced To Life Without Parole*, ASSOCIATED PRESS (May 28, 2019), https://apnews.com/f56b445a4e54468caff28c1844c55aa4.S.

[407] *Id.*

[408] *Id.*

[409] Fernandez et al., *supra* note 6; Rosenberg et al., *supra* note 7.

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documented history of mental treatment for depression and rage and typically threatened violence against superiors when disciplined while failing in his career in the Air Force.[410] He had escaped from confinement for psychiatric evaluation and treatment several years before his attack in Sutherland Springs:

> While Mr. Kelley awaited court-martial, the Air Force sent him to a civilian psychiatric hospital in Santa Teresa, N.M., where, according to local emergency dispatch records, he was given medication for depression, anxiety and attention deficit hyperactivity disorder, and was considered a "high-risk patient."
>
> On the night of June 7, 2012, Mr. Kelley escaped, made his way 12 miles south in the desert night to the El Paso bus station and bought a ticket home.
>
> His counselor at the hospital called the police, according to a police report, warning that Mr. Kelley had talked about killing his chain of command in the Air Force and told other patients he had recently bought guns online.[411]

Kelly had a documented history of mental illness, threats of violence against superior officers triggered by discipline, hospitalization for mental illness, and access to weapons.[412] There had even been an appropriate warning to law enforcement concerning his threatened violence, but despite those factors likely giving rise to the duty to warn or protect potential victims, the actual warning failed to prevent the massacre at the First Baptist Church culminating in his suicide some five years after his escape from confinement in the mental hospital caused by his aberrant behavior.[413] What is also part of the scenario is that Kelly was able to obtain guns based on a failure by the Air Force to comply with legal requirements for reporting that allowed him "to buy firearms after the Air Force failed six times to follow procedures that would have alerted the FBI to his criminal record."[414]

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[410] Dave Phillips, Richard Oppel, Jr. & Serge F. Kovaleskinov, *In Air Force, Colleague Feared Church Gunman Would 'Shoot Up the Place,'* N.Y. TIMES (Nov. 11, 2017), https://www.nytimes.com/2017/11/11/us/devin-kelley-air-force.html?&moduleDetail=section-news-2&action=click&contentCollection=U.S.&region=Footer&module=MoreInSection&version=WhatsNext&contentID=WhatsNext&pgtype=article.

[411] *Id.*

[412] *Id.*

[413] *Id.*

[414] Daniel Flatley, *Air Force's Repeated Errors Let Sutherland Springs Shooter Buy Firearms*, STARS & STRIPES (Dec. 6, 2018), https://www.stripes.com/news/us/air-force-s-repeated-errors-let-sutherland-springs-shooter-buy-firearms-report-says-1.559597 ("The Air Force's failure to submit Kelley's information allowed him to pass federally mandated background checks and to purchase four firearms from federally licensed dealers. He used three of the four firearms to kill 26 people and wound 22 others, according to the report. He then killed himself by shooting himself in the head.").

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Even in circumstances that presented close to an optimal situation for the use of a warning designed to protect against violence committed against third persons, warnings may well fail due to failures in the system suggested for prevention. Moreover, although the attack was committed against a place of worship, there was apparently no evidence that the shooting was targeted at the First Baptist Church itself or members of its congregation, or that there was an ideological or anti-Christian motivation for Kelly's actions. Instead, they might have simply reflected his intent to commit a *random* act of mass violence, which would not have been reasonably predicted by mental health professionals, while violence directed at military superiors would clearly have been suggested by his prior behavior and expressions of threats.

Only in situations in which a disaffected member of a religious community is individually identified, or when threats are directed at a specific religious community, could a duty to warn or protect third persons from injury arise. Even then, for the mental health professional to make a specific warning or take other action, the threat would have to be disclosed by an individual being evaluated or treated by the mental health professional. Otherwise, mass violence directed against any particular religious group or institution will not be prevented by a mental health professional acting as required by *Tarasoff*, whether the duty to warn has been recognized judicially as a matter of *duty* in terms of negligence or legislative definition.

b. Entertainment Venues, Theaters, and Bars

The problem posed by expecting mental health professionals to predict potential violence jeopardizing third persons targeted at entertainment venues lies in two common factors. First, unless the prospective perpetrator is a patient, there is no possibility that the mental health professional will have any reason to anticipate violence that might be prevented by a warning. Second, there is no necessary connection between even a patient threatening violence and any particular entertainment venue where an act of mass violence might be perpetrated. For instance, the killing of four persons and wounding of thirteen others at the Gilroy Garlic Festival in July 2019, in California suggested no particular motive for the shooter's use of a semi-automatic rifle related to the festival or attendees.[415] But he had posted shortly before on social media a message directing people to read *Might is Right*, a book described as commonly used to "justify racism, slavery and

[415] *See* Vives et al., *supra* note 16.

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colonialism."[416] There was, apparently, no basis for predicting the eighteen-year-old assailant's specific motivation in attacking this public event that might have warranted a warning of potential violence.

The exception might arise when a mass shooting is related to a specific event, such as the Aurora, Colorado theater shooting that occurred when *The Dark Knight Rises* was the feature being shown that night.[417] In that discrete situation,[418] disclosure of an intended threat based on a specific aspect of the event could trigger the need for a general warning from the mental health professional to law enforcement officials or emergency hospitalization.[419]

The nation has also seen a number of mass shootings at bars and other establishments at which consumption of alcohol is common, such as the shooting at the Borderline Bar & Grill in Thousand Oaks, California on November 7, 2018, in which thirteen died and ten others were wounded.[420] Another instance was the Ned Peppers Bar shooting in Dayton, Ohio, that occurred on August 4, 2019, in which ten were shot fatally—including the shooter—and twenty-seven others wounded with an "AR-15 style" firearm.[421] There was apparently no disclosure of any intent by either shooter of hostility directed at either establishment or history of an employment dispute or other specific cause for the attack.

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[416] *Id.*

[417] *See* Sandell et al., *supra* note 37 and accompanying text.

[418] *See* Gonzalez, *supra* note 36 (noting concern that theatrical opening of *Joker* could be accompanied by act of mass violence, similar to the mass shooting during *The Dark Knight Rises*).

[419] A popular entertainment event or venue could provide a trigger for mass violence, such as the Manchester, England, concert bombing, but without specific threat or identification of the target venue, the likelihood that any warning of patient hostility would be sufficient to prevent violence, leaving emergency hospitalization the most viable option for a mental health professional concerned over indications of potential patient violence. *The Latest on the Manchester Bombing Investigation*, *supra* note 59.

[420] Jennifer Medina, Dave Philipps & Serge F. Kovaleski, *Dueling Images: A Smiling Young Marine and a Killer Dressed in Black*, N.Y. TIMES (Nov. 8, 2018), https://www.nytimes.com/2018/11/08/us/ian-david-long-california-shooter.html. The 28-year-old perpetrator was a Marine Corps veteran thought to have suffered from PTSD following deployment to Afghanistan. *Id.*

[421] Cameron Knight, *Dayton Shooter Used a Gun That May Have Exploited an ATF Loophole*, CIN. ENQUIRER (Aug. 6, 2019), https://www.cincinnati.com/story/news/crime/crime-and-courts/2019/08/05/dayton-shooter-used-gun-may-have-exploited-atf-loophole/1920506001/; Hunt, *supra* note 17. The shooter had a history of mental illness, had composed "kill list" and "rape list" while in high school and was with his sister at the bar when he opened fire, killing his sister during the episode. Mitchell et al., *supra* note 17.

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With respect to the Pulse nightclub shooting in Orlando in June 2016,[422] however, there was reported speculation that the venue might have been targeted because it was frequented by gay men.[423] Further, there was speculation that the Muslim shooter was troubled by his personal sexual orientation, but law enforcement authorities ultimately concluded that there was no credible evidence supporting this speculation.[424] One of the most common problems in the evaluation of perpetrator intent in these mass shootings has been the difficulty in differentiating between speculation and proof of the actor's actual intent, rendering conclusions about the possibility of frustrating their actions by intervention by law enforcement. This problem also complicates the evaluation of potential effectiveness of warnings that might have been given by mental health professionals complying with their obligations under *Tarasoff*—an impossibility in any event if the shooter had not been treated or evaluated for psychiatric or emotional problems and disclosed the threat to commit an act of violence directed at a specific individual or venue. The effectiveness of warnings almost certainly cannot generally be accurately determined, in any sense. Often, the motives of mass shooters are impossible to assess because they are killed in the episode, as Pulse nightclub shooter Omar Mateen was.[425]

One possibility for protection against mass shootings involving entertainment venues for events that does not rest on a specific warning of the target lies in the option of enforcing greater screening of attendees as they enter the venue for an event. Much as attendees are often screened to prevent entry with prohibited items, including food or drink—specifically alcoholic beverage—the sponsor or operator

[422] Zambelich & Hurt, *supra* note 45.

[423] Hennessy-Fiske et al., *supra* note 63.

[424] *See* Goldman, *supra* note 62.

[425] Zambelich & Hurt, *supra* note 45. Mateen was killed by police fire during the shooting, but evidence showed that he claimed to be an "Islamic soldier" and during one of several 911 calls made during the shooting said:

> "I wanna let you know, I'm in Orlando and I did the shootings," the gunman told the operator during this 50-second call, according to a transcript released by the FBI.
> "What's your name?" the operator asked.
> "My name is I pledge of allegiance to Abu Bakr al-Baghdadi of the Islamic State."

Id. For an overview of the investigation and litigation history that may follow an act of mass violence, see *Omar Mateen*, ASSOCIATED PRESS, apnews.com/OmarMateen (last visited June 6, 2021).

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of the event venue might employ screening specifically designed to detect weapons to provide protection against shootings.

Similarly, mass shootings targeting individuals at bars or drinking establishments[426] may be subject to an additional possibility for prevention regardless of whether there has been a threat made that would provide information triggering a warning or other action addressing the intended violent act. That would involve restricted entry for inspection of weapons, as well as contraband, by security personnel—"bouncers"—at the entrance to the establishment. While more aggressive searching of individuals entering an event or establishment where entry may typically involve some minimal effort at security could be a source of complaints, it could also serve to deter individuals, who intend to commit acts of mass violence, from entering any venue with restricted admission by ticket or otherwise.[427]

c. Retail Settings and Malls

One of the most dramatic recent mass shootings occurred at a retail center and involved the killing of twenty-three and wounding of over twenty-four people at a Walmart store in El Paso, Texas, on August 6, 2019.[428] This shooting was not the

[426] *See, e.g.*, Gonzales, *supra* note 36 (the Borderline Bar & Grill Shooting in Thousand Oaks, California on November 7, 2018, committed by a marine veteran with a semi-automatic pistol before committing suicide); Hunt, *supra* note 17 (the mass shooting at the Ned Peppers Bar in Dayton, Ohio, where the gunman used an AR-15 style firearm to kill ten and wound twenty-seven others); Goldman, *supra* note 62 (the killing of forty-nine victims at the Pulse nightclub in Orlando, Florida).

[427] Moreover, the recognition of a duty for owners or operators to provide minimum levels of screening for weapons to protect customers resulting in liability for owners and insurers in the event of injury of patrons that could reasonably have been prevented would support adoption of aggressive, or more aggressive screening procedures designed to deny admission to potential perpetrators of violent acts threatening third persons. *See* Michael Steinlage, *Liability for Mass Shootings: Are We at a Turning Point*, ABA (Feb. 7, 2020), https://www.americanbar.org/groups/tort_trial_insurance_practice/publications/the_brief/2019-20/winter/liability-mass-shootings-are-we-a-turning-point/. This comprehensive review of litigation arising from episodes of mass violence occurring at private enterprises provides an excellent insight into the reasoning of appellate courts addressing arguments relating to duty of owners or operators to protect against such episodes. The author argues that traditional hesitance to impose duty on enterprises to protect against violence that would injure third persons is changing: "As mass shooting incidents become more frequent and widely reported, the perception of whether such events are foreseeable has begun to shift." *Id.*

[428] Manny Fernandez & Sarah Mervosh, *Soccer Coach in El Paso Shooting Dies 9 Months Later*, N.Y. TIMES (Apr. 17, 2020), https://www.nytimes.com/2020/04/27/us/el-paso-shooting-guillermo-memo-garcia.html. The Times reported on the deceased, 36-year-old Guerillo Garcia:

> Mr. Garcia used his size and his instincts to shield his wife and son, according to an account published in The Houston Chronicle. With his back to the

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first mass shooting having occurred at a mall, an earlier shooting having taken place in Clackamas, Oregon, 2012.[429]

One of the most difficult problems to address with respect to mass shootings involves those that occur in shopping malls.[430] In many situations, the difficulty posed lies in the fact that these locations are generally open and available for the perpetrator interested in engaging in an act of mass violence. Because these locations are readily accessible, the prospective perpetrator who has formulated a plan for a mass shooting is unlikely to be physically restrained from the venue in which the shooting will occur. Even if a treating mental health professional is advised of the mentally disturbed patient's intent to commit a violent act generally—unless a specific target, whether individual or location, is also disclosed—the mental health professional can only make a general warning as to the patient's intended act of violence.

However, a warning based upon a patient's disclosure and the treating professional's evaluation that the patient has the means to commit the threatened act of violence could be valuable in terms of emergency hospitalization to avoid further action by the patient. Emergency hospitalization offers the opportunity to obtain evaluation and treatment, with the potential for neutralizing the patient's ability to move forward in implementing the intended act of violence. In this way, credible threats made by patients suggesting likely actualization of hostility or desire to engage in public behavior resulting in momentary fame might be successfully frustrated by a timely threat related to law enforcement authorities by the reporting professional.

Nevertheless, without disclosure of a threat targeting individuals randomly present at a particular venue, such as a shopping mall, those individuals will almost always be beyond protection prior to commission of the terroristic act. Generally,

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> gunman, he absorbed many of the bullets. The gunman, who is white, later confessed and told the police that he had targeted Mexicans, the authorities said. A four-page manifesto attributed to the perpetrator said the attack was being carried out in "response to the Hispanic invasion of Texas." He now faces federal hate-crime charges.

Id.

[429] Shoichet & Martinez, *supra* note 53.

[430] *See, e.g.*, *8-Year-Old Boy Killed, Girl and 2 Adults Injured in Shooting At Alabama Mall*, CBS NEWS (July 4, 2020, 8:03 A.M.), https://www.cbsnews.com/news/alabama-mall-shooting-royta-giles-killed-riverchase-galleria/.

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those venues will remain unprotected from acts of mass violence by a perpetrator selecting the venue for their action without notice.

C. Specific Motivation Unique to the Individual Shooter

Unlike those scenarios that offer the most typically fertile potential for identifying probable patient violence, situations in which the patient's motivation is related to undisclosed personal hostility based upon perceived injustice or motivation are likely less promising. The former may be attributed to personal attacks, such as bullying among younger people[431] or adults who have suffered from long-term feelings of inadequacy symptomatic of emotional distress or personality disorders that may be manifested in desire for revenge or some show of aggression designed to respond to those who have belittled, severely criticized, or bullied them.[432] In these

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[431] Julia Lurie, *Bullying Victims Are Twice as Likely to Bring a Weapon to School*, MOTHER JONES (May 5, 2014), https://www.motherjones.com/politics/2014/05/bullying-victims-carry-weapons-guns/. The story notes:

> A new study based on a survey of more than 15,000 American high school students found that victims of bullying are nearly twice as likely to carry guns and other weapons at school. An estimated 200,000 victims of bullying bring weapons to school over the course of a month, according to the authors' analysis of data from the Centers for Disease Control's 2011 Youth Risk Surveillance System Survey. That's a substantial portion of the estimated 750,000 high school students who bring weapons to school every month.

Id.

[432] *See id.* ("For years, anti-bullying groups have drawn a connection between bullying and school shootings. . . . However, focusing too much on bullying as a cause of school shootings may distract from other important factors, such as mental health and access to weapons."); *see also* Jeff Zisner, *Bullying in School Is a Leading Cause of Active Shooters & School Violence*, AEGIS SECURITY & INVESTIGATIONS (Oct. 1, 2017), https://www.aegis.com/bullying-in-school-is-a-leading-cause-of-active-shooters-school-violence/. AEGIS is a private firm providing clients with protective services including active shooter training, https://www.aegis.com/survive-active-shooter-training/ (last visited June 6, 2021). The contractor advises in explaining its services the relationship between victims of school bullying and later violence:

> Furthermore, bullying has been linked to active shooter thoughts and actions. Columbine, the most notorious school shooting in modern history that prompted extreme responses in schools to take preventative action, has often had bullying cited for the shooters' motives. Most recently, Freeman High School in Spokane, WA suffered an active shooter incident where the perpetrator openly admitted to the police that his lesson was to "teach them a lesson" (e.g. teachers and students there) about bullying, demonstrating this very real link.

Zisner, *supra*. The author's reference to the Spokane school shooting involved a fifteen-year-old boy who took a gun from his father's safe and shot four students, killing one, who stated in an affidavit "Instead

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instances, the therapist may well be aware of the cause of anxiety for the patient but lack actual knowledge of how the patient's propensity for violence might be manifested. This is not uncommon, as even law enforcement agencies may be caught off-guard by innovations in the infliction of mass violence, perhaps as is evident by the failure of security experts to either anticipate or protect against the use of commercial airliners in the commission of suicide attacks such as the assault on the World Trade Center in 2001.[433]

Two episodes of mass shooting illustrate the problem posed by unanticipated, or apparently unanticipated, acts of planned violence against unidentified victims. First, in July 2016, a lone gunman ambushed law enforcement officers who were providing protection during an otherwise non-violent Black Lives Matter protest in downtown Dallas, Texas. The gunman killed five officers and wounded seven others.[434] The shooter, an honorably discharged Army reservist who had been deployed in Afghanistan and had no prior criminal record, was reportedly disturbed by the killing of Black men by white police officers.[435] Second, the mass shooting at the Las Vegas open-air concert in October 2017 resulted in the deadliest episode of mass violence by a single individual, eclipsing the Orlando nightclub massacre[436]

he'd come to the school to teach everyone a lesson about what happens when you bully others." *Id. See* Sonya Hamasaki & Nicole Chavez, *Suspect in Spokane's School Shooting Wanted To "Teach Everyone a Lesson,"* CNN (Sept. 15, 2017), https://www.cnn.com/2017/09/13/us/washington-spokane-school-shooting/index.html.

[433] NAT'L COMM'N ON TERRORIST ATTACKS UPON THE U.S., THE 9/11 COMMISSION REPORT: EXECUTIVE SUMMARY 7 (2004), https://govinfo.library.unt.edu/911/report/911Report_Exec.pdf ("On 9/11, the defense of U.S. air space depended on close interaction between two federal agencies: the Federal Aviation Administration (FAA) and North American Aerospace Defense Command (NORAD). Existing protocols on 9/11 were unsuited in every respect for an attack in which hijacked planes were used as weapons.").

[434] Jason Whitely, *In Year Since Dallas Police Ambush, What Happened to Movement for Black Lives?*, USA TODAY (July 7, 2017), https://www.usatoday.com/story/news/nation-now/2017/07/07/dallas-police-ambush-anniversary/458218001/.

[435] William Arkin, Tracy Connor & Jim Miklaszewski, *Dallas Shooter Micah Johnson Was Army Veteran and 'Loner,'* NBC (July 9, 2016), https://www.nbcnews.com/storyline/dallas-police-ambush/dallas-shooter-micah-xavier-johnson-was-rmy-veteran-n606101. The shooter reportedly had a cache of weapons and bombing making components in his home and had worked as an "aide for mentally challenged children and adults" following his military discharge. *Id.*

[436] Zambelich & Hurt, *supra* note 45.

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and Charles Whitman's University of Texas Tower shooting rampage[437] in terms of the number of fatalities and victims randomly wounded.

The problem posed by the dual concerns—the correct evaluation of the risk posed by a mentally imbalanced patient and the need for identification of a prospective victim of patient violence—make the imposition of a duty to warn or protect potential victims difficult to justify in light of traditional principles of tort law in many, perhaps most, cases of patient violence. This is likely particularly true when the patient's hostility is prompted by conceptions or idealized sources of oppression bearing on the patient, rather than other individuals.

Further, those acts of violence that are readily characterized as the product of political, religious, or social terrorism may be least likely to be disclosed in the context of mental health therapy. This seems likely because the individual's belief system would not appear to be consistent with the need for therapy, although individuals may be forced into the evaluation as a result of indications of dangerousness. In this respect, the subject may develop extreme political or religious views in the progression toward a disordered mental state, which emanates from paranoia and ultimately renders the shooter psychotic.

The suggestion that perpetrators are motivated by mental illness and psychosis is probably flawed. Those who argue that acts of mass violence are most likely caused by mental illness may reach that conclusion because they do not share the belief systems—whether political or religious, for instance—of those who commit the acts. The danger in this approach, evidenced by President Trump in his explanations that mental illness, not the availability of firearms, is the cause of mass

[437] On August 1, 1966, Americans were exposed to the reality of televised mass violence as Charles Whitman opened fire on random victims from his position atop the twenty-eight story "Tower," the administration building and library at the University of Texas in Austin. *See* GARY LAVERGNE, A SNIPER IN THE TOWER (1997). After earlier killing his mother and wife by stabbing them to death, Whitman entered the University's Tower and took the elevator to the observation deck at the top of the building, securing the position to embark on a shooting spree in which he killed sixteen people and wounded thirty-one over ninety-six minutes. Philip Jankowski, *50 Years Ago, the Unthinkable Became Thinkable*, WASH. TIMES (July 24, 2016), http://www.washingtontimes.com/news/2016/jul/24/50-years-ago-the-unthinkable -became-thinkable/ (reporting that Neal Spelce, Austin broadcaster, covered the story from just outside the sniper's range). To access the live report, see Fox 7 Austin, *KTBC News UT Tower Shooting Special Report|Austin, TX 1966*, YOUTUBE (Aug. 1, 2016), https://www.youtube.com/watch?v=bBtrFS-C1ug, to access the live report. For contemporaneous video of the incident, see Whitney Milam, *Sniper 66—the Charles Whitman Murders Part 1*, YOUTUBE (Feb. 7, 2014), https://www.youtube.com/watch?v=MKtP57U0nnM. The video includes actual footage of the incident, interviews and commentary, and reconstructions relating to Whitman's life before the shooting. *See id.*

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shootings,[438] is that it simplifies causation and seemingly shifts resolution of the cause from uncontrolled access to weaponry to treatment for mental disorders. In fact, those responsible for mass violence may not suffer from any disorder, but instead, are committed to an ideology inconsistent with the norms of thinking in the United States.

Significant episodes of mass shootings may be traced to ideological conflict based on ethnic, political, or religious intolerance. For instance, the San Bernardino, California, shooting in 2015, in which a heavily-armed couple attacked the social services facility and its employees where the husband had worked for a number of years as an environmental inspector,[439] appeared to law enforcement to have been the product of an internet inspired terroristic motivation for the Pakistani couple.[440] Similar to other terrorists, the couple who terrorized San Bernardino did not provide any information foreshadowing their intended violence and, in fact, apparently acted on short notice.[441] Of course, other perpetrators have provided precisely this kind of information, foreshadowing their intended acts of violence, often through internet conversations or postings. For example, the El Paso Walmart shooter posted a manifesto against Mexican-Americans and Latino immigrants on the internet

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[438] *See* Rogers, *supra* note 9.

[439] Adam Nagourney, Ian Lovett & Richard Pérez Peña, *San Bernardino Shooting Kills at Least 14; Two Suspects Are Dead*, N.Y. TIMES (Dec. 2, 2015), https://www.nytimes.com/2015/12/03/us/san-bernardino-shooting.html.

[440] Adam Goldman, Mark Berman & Missy Ryan, *San Bernardino Shooter's Former Neighbor Who Bought Rifles Is Cooperating With Authorities*, WASH. POST (Dec. 10, 2015), https://www.washingtonpost.com/news/post-nation/wp/2015/12/09/san-bernardino-attackers-talked-about-jihad-and-martyrdom-in-2013/. The *Post* reported that former FBI Director James Comey, testifying before the United States Senate, told Senators that the couple had been radicalized long before the assault, relating:

> The husband-and-wife duo "were radicalized for quite a long time before their attack," Comey reiterated during an appearance on Capitol Hill in front of the Senate Judiciary Committee. This follows earlier statements by investigators that the couple had been adherents of a radical strain of Islam long before the massacre.
> "And online . . . as early as the end of 2013, they were talking to each other about jihad and martyrdom before they became engaged and then married and lived together in the United States," Comey said during his testimony.

Id.

[441] Nagourney et al., *supra* note 439 ("On Wednesday morning [Farook] attended a holiday party for the department at the Inland Regional Center, a sprawling facility that provides services for thousands of people with disabilities. He left 'angry' after a dispute of some sort, the chief said, and returned with Ms. Malik around 11 a.m.—heavily armed.").

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explaining the mass shooting he subsequently committed;[442] while shooters in the New Zealand[443] and San Diego[444] episodes posted anti-Islamic statements on the internet; shooters in Charleston[445] and Lafayette, Louisiana,[446] posted internet statements attacking African-Americans; and the perpetrator of the Tree of Life shooting in Pittsburgh posted an anti-Semitic, pro-Nazi rant.[447]

To the extent that potential perpetrators of acts of mass violence provide information in forums accessible to law enforcement and intelligence officials or the public generally, it is possible that those acts will be frustrated or prevented[448] in

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[442] Bogel-Burroughs, *supra* note 15; *see also* Kevin Rouse, *'Shut the Site Down,' Says the Creator of 8chan, a Megaphone for Gunmen*, N.Y. TIMES (Aug. 4, 2019), https://www.nytimes.com/2019/08/04/technology/8chan-shooting-manifesto.html. The *Times* article reports on "8chan," which it described as an "online message board as a free speech utopia." *Id.* "But now, 8chan is known as something else: a megaphone for mass shooters, and a recruiting platform for violent white nationalists." *Id.* The *Times* reporter also relates "8chan" to the El Paso shooting:

> Moments before the El Paso shooting on Saturday, a four-page message whose author identified himself as the gunman appeared on 8chan. The person who posted the message encouraged his "brothers" on the site to spread the contents far and wide. In recent months, 8chan has become a go-to resource for violent extremists. At least three mass shootings this year—including the mosque killings in Christchurch, New Zealand, and the synagogue shooting in Poway, Calif.—have been announced in advance on the site, often accompanied by racist writings that seem engineered to go viral on the internet.

Id.

[443] *Nationwide Anti-Mosque Activity*, *supra* note 396.

[444] Power & Choy, *supra* note 398.

[445] Ford & Chandler, *supra* note 43.

[446] *See* sources cited *supra* note 41.

[447] Robertson et al., *supra* note 14.

[448] For example, security officers at the Corpus Christi (Texas) Naval Air Station shot and killed a Syrian-born individual believed to have subscribed to a jihadist ideology as he attempted to enter the base on May 21, 2020, preventing what officials believed to be a terrorist attack on the facility. *See Statement from Acting Secretary Wolf on Corpus Christi Shooting*, US DEPARTMENT OF HOMELAND SECURITY (May 22, 2020), https://www.dhs.gov/news/2020/05/22/statement-acting-secretary-wolf-corpus-christi-shooting; *see also* Dakin Andone, Barbara Starr, Hollie & Josh Campbell, *Texas Naval Base Shooter Believed To Have Expressed Support for Terrorist Groups Online*, CNN (May 22, 2020), https://www.cnn.com/2020/05/21/us/naval-air-station-corpus-christi-lockdown/index.html. Previously, on December 6, 2019, a member of the Royal Saudi Air Force in training at the Pensacola Naval Air Station, killed three and injured eight others, in what the FBI characterized as a terrorist attack. The shooter was identified as an Islamic jihadist based on evidence that after visiting the 9/11 memorial in New York on September 11, 2019, he had posted a message on social media exactly one year later saying "the countdown has started." *See Shooting At Naval Air Station Pensacola Called 'Act of Terrorism': Deceased Assailant's Locked*

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some instances. But, the fact that the investigation after the violent act may turn up evidence of motivation for the mass assault does not provide law enforcement with information in all cases sufficient to prevent the episode. In this sense, law enforcement is no more able to predict and prevent mass shootings than mental health professionals since it is the disclosure of an intended act directed against a disclosed individual or another ascertainable target that is necessary for intervention to prevent the violence. However, in the case of Coast Guard officer Christopher Hasson, federal officials acted prior to the commission of any act of violence based upon concern for his intent and his possession of unlawful weapons.[449] His potential victims were described by federal prosecutors as "journalists, Democratic politicians, professors, Supreme Court justices and those he described as 'leftists in general,'"[450] Hasson's case reflected such significant concern that the usual reticence to act against motivation arguably protected under the First Amendment was overruled by the potential severity of the threat he posed.[451]

Phones a Hurdle for Investigators, FBI (Jan. 13, 2020), https://www.fbi.gov/news/stories/naval-air-station-pensacola-shooting-called-act-of-terrorism-011320.

[449] Dave Phillips, *Christopher Hanson, Coast Guard Officer, Plotted Attacks at his Desk, Filings Say*, N.Y. TIMES (Feb. 21, 2019), https://www.nytimes.com/2019/02/21/us/coast-guard-christopher-hasson-terrorist-attack.html?action=click&module=RelatedLinks&pgtype=Article ("In court filings, prosecutors said he was also a 'domestic terrorist' and self-described white nationalist who studied the methods of the Unabomber, the Virginia Tech gunman and other extremist killers; stockpiled guns and drugs; drew up a target list of prominent cable news journalists and Democratic politicians to be killed; and wrote, prosecutors said, of wanting 'to murder innocent civilians on a scale rarely seen in this country. . . .' Prosecutors say that for at least two years, Lieutenant Hasson visited white supremacist and neo-Nazi websites, and studied the 1,500-page manifesto written by Anders Behring Breivik, a far-right Norwegian extremist who killed 77 people in 2011. They said that he also took the synthetic opioid Tramadol while at work and that he had obtained the drug illegally."). Much of the material relied upon by prosecutors was recovered from Hanson's computer. *Id.*

[450] Michael Levenson, *Former Coast Guard Officer Accused of Plotting Terrorism Is Sentenced to 13 Years*, N.Y. TIMES (Jan. 31, 2020), https://www.nytimes.com/2020/01/31/us/christopher-hasson-coast-guard-terrorism.html.

[451] *Id.* Federal prosecutors explained:

> Federal prosecutors had asked that Mr. Hasson be sentenced to 25 years in prison. In a court filing, they said that Mr. Hasson was inspired by racist murderers, stockpiled assault weapons, studied violence and intended to "exact retribution on minorities and those he considered traitors."
>
> Prosecutors said that Mr. Hasson had identified as a white nationalist for more than 30 years and had, in writing, advocated "focused violence" in order to establish a white homeland.
>
> "Christopher Hasson intended to inflict violence on the basis of his racist and hateful beliefs," Robert K. Hur, the United States attorney in

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With respect to the varieties of ideological motivation causing terroristic acts of mass violence, it is possible to categorize these, as one scholar, Dr. Haroro Ingram, has. He described the problem of tracing potential violence in three different contexts, based on the findings of the National Strategy for Counterterrorism issued in 2018:[452]

- First, terroristic violence committed by a variety of right-wing and racially-motivated extremists remains the most common form of ideologically-motivated violence in the United States.
- Second, the threat posed by homegrown jihadists, especially those inspired by Al-Qaeda or the Islamic State, persists as a major domestic security concern.
- Third, the diversity of ideological-motivations driving violent extremist activism in the United States represents a significant challenge in itself. Indeed, this diversity may be even greater given the motivations of some lone shooters. Moreover, this diversity contributes to a volatility within the security environment as threats posed by certain groups and actors (e.g. extreme right) may contribute to the mobilization of other groups and actors (e.g. the extreme left) in a "counter-movement" dynamic.[453]

> Maryland, said in a statement Friday. "As long as violent extremists take steps to harm innocent people, we will continue to use all of the tools we have to prevent and deter them."

Id.

[452] The National Strategy for Counterterrorism is created by the National Counterterrorism Center and published by the White House. THE WHITE HOUSE, NATIONAL STRATEGY FOR COUNTERTERRORISM OF THE UNITED STATES OF AMERICA (2018), https://www.dni.gov/files/NCTC/documents/news_documents/NSCT.pdf. The National Counterterrorism Center was initially created by President George W. Bush in the aftermath of the September 11, 2001, attack on the World Trade Center to provide a focal point for collection and assessment of information relating to terrorist activity, operating within the Office of National Intelligence. *History*, OFF. DIRECTOR NAT'L INTELLIGENCE: NAT'L COUNTERRORISM CTR., https://www.dni.gov/index.php/nctc-who-we-are/history (last visited June 6, 2021).

[453] *See* HARORO J. INGRAM, TERRORISM PREVENTION IN THE UNITED STATES: A POLICY FRAMEWORK FOR FILLING THE CVE VOID (2018), https://extremism.gwu.edu/sites/g/files/zaxdzs2191/f/Terrorism%20Prevention%20Policy%20Paper.pdf. Dr. Ingram is a researcher with Coral Bell School, Australian National University (Canberra), focusing on the use of propaganda by the Islamic State and the Afghan Taliban. He served as a research associate with the George Washington University Program on Extremism when he published this analysis. *Haroro J. Ingram*, AUSTRALIAN NAT'L U., http://bellschool.anu.edu.au/experts-publications/experts/haroro-j-ingram (last visited June 6, 2021).

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His analysis leads him to conclude: "Consequently, there is *no typical* demographic profile of an American violent extremist."[454]

Diversity of terrorists explains much of the problem faced by law enforcement and intelligence officers in attempting to anticipate and prevent mass violence. Moreover, even if information concerning the intent of terrorists—doctrinal posts or rants, included—preventive action only results in frustration of the intended violence if the information provides insight into the timing, venue, and nature of the intended act. Without foreknowledge of planned violence, the sheer numbers of individuals engaging in the dialogue of hate cannot possibly afford counter-terrorism officials a reasonable basis for action. In some cases, a violent act may be frustrated, but consistent with the common law tradition of responding to criminal acts with prosecution and punishment—other than when evidence is sufficient to warrant prosecution for conspiracy to commit an act of mass violence[455]—the available data will likely provide only information concerning an episode after it happens, and the suspect or suspects have been identified.[456]

In addition, Dr. Ingram's first trend of terrorism, including domestic terrorism emanating principally from the far right, identifies a dangerous source of potential violence not necessarily ideological in nature, at least in the context of traditional political or religious ideologies reflected in acts of mass violence. The diversity

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[454] *Id.*

[455] Prevention of terrorist acts having their roots in international plots or acts planned by foreign nationals does implicate use of prosecution resources to frustrate acts of mass violence. For a thorough analysis of counterterrorism and criminal prosecution, see Robert M. Chesney, *Beyond Conspiracy? Anticipatory Prosecution and the Challenge of Unaffiliated Terrorism*, 80 S. CAL. L. REV. 425 (2007). Investigation and prosecution of domestic terrorism or terroristic acts intended by citizens or others lawfully in the United States are subject to Constitutional protections, such as the First Amendment. *Id.*

[456] *See, e.g.*, Barrett et al., *supra* note 47. The *Washington Post* article, examining the repercussions from the terroristic attack in New York City, referenced the investigation of the Pulse nightclub shooter in Orlando noting:

> The FBI has, in the past, scrutinized people who have gone on to commit attacks. Perhaps most notably, agents investigated Omar Mateen, who shot and killed 49 people last year in an Islamic State-inspired attack in an Orlando nightclub, for 10 months in 2013, even putting him under surveillance and recording his calls before ultimately closing the case.

Id. For information on the Pulse nightclub shooting see *supra* notes 45, 62, 422–25 and accompanying text.

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among domestic terrorists may be even greater, and monitoring those individuals and groups may be limited by constitutional safeguards.

Certainly, there is a significant history of domestic terroristic episodes, including the most deadly act—the bombing of the Alfred P. Murrah Federal Building in Oklahoma City on April 19, 1995, the "worst act of homegrown terrorism in the nation's history."[457] If the Oklahoma City bombing was understood as an act of opposition to the United States government, a less readily explained source of potential terrorist activity not organized or necessarily politically directed has been identified on the internet associated with the "dark web"[458] and sites such as "4chan."[459] The site, among others, is heavily used by right-wing extremists, reflecting an increase in racist attacks over a number of years. Investigative journalist Janet Reitman, a contributing editor for *Rolling Stone* and the *New York Times*, observed:

> Between 2012 and 2016, according to a report by George Washington University's Program on Extremism, there was a 600 percent increase in followers of American white-nationalist movements on Twitter alone; white-nationalist groups now outperform ISIS in nearly every social metric. Analysts who study extremism note that both the far right and groups like ISIS use similar tactics, producing high-quality videos and employing memes and jokes to make their message more appealing. "The overall goal is to destabilize people so you can then fill them with your own views," says Keegan Hankes, a senior research analyst with the Southern Poverty Law Center. "If you make racism or anti-Semitism funny, you can subvert the cultural taboo. Make people laugh at the

[457] *Oklahoma City Bombing*, *supra* note 64.

[458] *See, e.g.*, Dan Rafter, *What Is the Dark Web?*, NORTONLIFELOCK, https://us.norton.com/internetsecurity-emerging-threats-what-is-the-deep-dark-web-30sectech.html (last visited June 8, 2021):

> The dark web gets plenty of headlines. That's because this part of the web is made up of hidden sites that you can't find through a conventional search engine. Dark web sites use encryption software to provide anonymity for their users and to hide their locations. It's why the dark web is home to so much illegal activity. If you tap into the dark web, you'll find everything from illegal drug and gun sales to pornography and online gambling.

[459] Andrew Thompson, *The Measure of Hate on 4Chan*, ROLLING STONE (May 10, 2018, 5:13 P.M.), https://www.rollingstone.com/politics/politics-news/the-measure-of-hate-on-4chan-627922/ ("It's difficult to find a single location—physical or otherwise—so inclusive to the disparate factions of the far-right as 4chan. Its 'politically incorrect' message board—/pol/—has served as a general assembly for all manners of right-wing contrarianism—and extremism—a political forum with a bone-deep elusiveness.").

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> Holocaust—you've opened a space in which history and fact become worthless, period."[460]

Another bizarre but potentially dangerous presence on the Internet also illustrates the problems involved in anticipating acts of mass violence. This involves the use of dark web sites to post false claims of violence or impending violence and identifying groups with contrary political perspectives in order to confuse authorities. For example, individuals identifying with the "boogaloo boys," an ultra-right-wing group described as "libertarians," shot two federal courthouse security officers employed to protect the federal courthouse in Oakland, California, on May 29, 2020, killing one.[461] The shooter was an Air Force sergeant who served as the head of the Phoenix Ravens, a unit tasked with defending military installations from terrorist assaults. He killed a deputy sheriff who was trying to effect his arrest.[462] An apparent motive for the assault was to falsely claim that responsibility for the shooting belonged to "antifa."[463] "For days, conservative news broadcasters pinned the blame on 'antifa,' the loosely affiliated group of anti-fascist anarchists known to attack property and far-right demonstrators at protests."[464]

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[460] *See* Janet Reitman, *All-American Nazis: How a Senseless Double Murder in Florida Exposed the Rise of an Organized Fascist Youth Movement in the United States*, ROLLING STONE (May 2, 2018, 8:00 A.M.), https://www.rollingstone.com/politics/politics-news/all-american-nazis-628023/.

[461] Dale Beran, *The Boogaloo Tipping Point, What Happens When a Meme Becomes a Terrorist Movement?*, ATLANTIC (July 4, 2020), https://www.theatlantic.com/technology/archive/2020/07/american-boogaloo-meme-or-terrorist-movement/613843/ ("According to prosecutors, [Steven] Carrillo and an accomplice, 30-year-old Robert A. Justus Jr., were part of the 'boogaloo' movement, a patchwork of right-leaning anti-government libertarians, Second Amendment advocates, and gun enthusiasts all preparing for another American civil war."). Beran is also the author of IT CAME FROM SOMETHING AWFUL: HOW A TOXIC TROLL ARMY ACCIDENTALLY MEMED DONALD TRUMP INTO OFFICE (2019).

[462] Beran, *supra* note 461.

[463] *Id.* The *Antifa* movement is composed of leftists and anti-racists who have been blamed for violence by President Trump. "They believe that law enforcement is complicit in white supremacy, and that democracy is in danger." *Antifa Explained*, WEEK (June 14, 2020), https://theweek.com/articles/919492/antifa-explained. *Antifa* operates in opposition to right wing groups such as the *Boogaloo Boys* and claimed involvement in opposing white supremacists in the "Unite the White" rally conducted in Charlottesville, Virginia, in August 2017. *Id.* The article concludes with this reference to a recent action by individuals self-identifying with the *Boogaloo Boys*: "Last week, three ex-military men who police say self-identify as Boogaloo Bois were arrested on the way to a Las Vegas Black Lives Matter protest with full gas cans and Molotov cocktails in their car." *Id.*

[464] Beran, *supra* note 461.

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The use of websites for propaganda or publication of political manifestos appears to be fully protected by the First Amendment unless the publishers are "inciting acts of violence."[465] The ability to use websites for the dissemination of extremist dogma and claims of violence committed or planned by political opponents or declaring responsibility for acts of violence almost certainly complicates the investigation and monitoring of extremist political views by law enforcement when those views include references to violence. Even more attenuated would be the likelihood that mental health professionals would have access to threats committed by individuals during the course of treatment or evaluation warranting action for the protection of third persons, regardless of the ideological perspective of a patient.

Yet another potential source of mass violence not affiliated with any ideological group using internet postings to disseminate radical views, whether reflecting ultra-right-wing or ultra-left-wing political philosophy, has been identified as originating with single men expressing common feelings of rejection by women and extreme anti-feminist views. An investigation into mass shootings published in the May/June 2019 issue of *Mother Jones*[466] offers a stark insight into the motivation of some male mass shooters not grounded in political ideology. The author of the article, Mark Follman, summarized his findings:

> Nailing down the motive behind a mass shooting is often difficult. Most shooters tend to be driven by a poisonous blend of entrenched grievances, personal setbacks, depression, rage, suicidal urges, and in some cases, serious behavioral disorders or mental illness. Rarely can their actions be explained definitively by a single factor. However, *Mother Jones*' in-depth database of mass shootings reveals a stark pattern of misogyny and domestic violence among many attackers. This factor is already relatively well known in cases where men gun down intimate partners, children, and other family members in their own or other people's homes.

[465] *See* Brandenburg v. Ohio, 395 U.S. 444, 447 (1969) ("[T]he constitutional guarantees of free speech and free press do not permit a State to forbid or proscribe advocacy of the use of force or of law violation except where such advocacy is directed to inciting or producing imminent lawless action and is likely to incite or produce such action.").

[466] Mark Follman, *Armed and Misogynist: How Toxic Masculinity Fuels Mass Shootings*, MOTHER JONES: CRIME & JUSTICE (May/June 2019) https://www.motherjones.com/crime-0justice/2019/06/domestic-violence-misogyny-incels-mass-shootings/ ("In at least 22 public mass shootings, the perpetrators had a history of domestic violence, targeted women, or had stalked and harassed women.").

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> There is also a strong overlap between toxic masculinity and public mass shootings, according to our latest investigation.[467]

The research found that in a significant number of mass shooting incidents, including those involving the Pulse nightclub in Orlando and the Sutherland Springs Baptist Church in Texas, the perpetrators had a history of prior violence against women. In twenty-two of the episodes occurring since 2011, domestic violence was believed to have been a possible contributing factor in the mass shooting and in at least two episodes: "The shooters bore the hallmarks of so-called 'incels'—a subculture of virulent misogynists who self-identify as 'involuntarily celibate' and voice their rage and revenge fantasies against women online."[468]

Regardless of the specific motivation of the perpetrator—whether the shooter identified as an "incel," for instance—there is evidence that significant numbers of victims of mass acts of violence are women. A study conducted by a gun-control advocacy group, Everytown for Gun Safety,[469] concluded that "[i]n more than half of all mass shootings in the United States from 2009 to 2017, an intimate partner or family member of the perpetrator was among the victims."[470]

This conclusion suggests that, with respect to a significant number of incidents, there would be an increased likelihood that a factor of anger or hate arising from interpersonal or family relationships would afford a greater likelihood that the perpetrator's anxiety expressed in threatened violence could serve to provide a basis

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[467] *Id.*

[468] *Id.* Similarly, Dale Beran expressed concern in a C-SPAN presentation that the anguish of males identifying with the "involuntarily celebrate" perspective could reflect thinking underlying fantasies of mass violence that would, for some of those involved, result in the commission of such acts. Those individuals, he observed, commonly spend inordinate amounts of time on the internet, often lived with their parents, watched Japanese *anime*—animated pornography, and often expressed fascination for acts of mass violence, opining that these individuals were prepped to commit violence culminating in suicide while filming the experience. *It Came From Something Awful*, C-SPAN (July 30, 2019), https://www.c-span.org/video/?463096-1/it-awful.

[469] Everytown for Gun Safety is a gun control lobbying group founded by mayors Michael Bloomberg of New York City and Thomas Menino of Boston in April 2006. They co-authored an op-ed piece, *Some Gun Rules We Can All Agree On*, WALL ST. J. (June 30, 2008, 12:01 A.M.), https://www.wsj.com/articles/SB121478283640414407.

[470] Julie Bosman, Kate Taylor & Tim Arango, *A Common Trait Among Mass Killers: Hatred Toward Women*, N.Y. TIMES (Aug. 10, 2019), https://www.nytimes.com/2019/08/10/us/mass-shootings-misogyny-dayton.html.

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for warning or other protective action.[471] However, the likelihood that a professional's determination that warning or other action is appropriate—following the *Tarasoff* principle applicable based upon statutory or judicial recognition of a duty for the mental health professional to warn—will depend upon whether the threat has been disclosed by a potentially violent patient during therapy. Nonetheless, the mental health professional might also rest a decision to warn or otherwise act on a disclosure made by a prospective *victim* of fear of violence during *their* therapy. The therapist's professionally sound decision to take action to initiate involuntary commitment proceedings as a response to a threat of violence disclosed by a prospective victim would typically be protected from civil liability under statutory or judicially recognized immunity.[472]

The sources of motivation for mass acts of shooting violence are difficult to trace and characterize, particularly when there is no likely connection between the shooter's source of anger and some identifiable circumstance, such as family relationships, employment or workplace, schools, or hospitalization. These special characteristics may reflect circumstances in which the potential perpetrator discloses their specific intent to commit an act of violence. Some of these potential perpetrators may disclose violent thinking during the course of mental health treatment, possibly giving rise to the duty to warn their potential victims, the duty recognized in *Tarasoff* and post-*Tarasoff* judicial decisions or legislative enactments. Even when there is evidence of potential violence that is not disclosed while the individual is threatening violence toward others, the expert assessments of mental health professionals may provide understanding for the necessity of intervention to protect third persons from injury and assistance in identifying those individuals for whom the intervention is appropriate.

VI. MASS SHOOTINGS AND MENTAL HEALTH: CAUSATION AND THREAT ASSESSMENT

President Trump's inference that Stephen Paddock, who committed the nation's single worst mass shooting from an upper-story hotel room in the Mandalay Bay Hotel in Las Vegas, suffered from a mental illness represents his common

[471] *See supra* Section B.1.b.

[472] Action to seek emergency involuntary civil commitment for evaluation and treatment based on the threat would typically protect the mental professional from subsequent civil action by the individual involuntarily committed by immunity based on an applicable state statute or judicial doctrine. For references to immunity for mental health professionals acting to restrain dangerous individuals through involuntary hospitalization, *see, e.g.*, *supra* notes 70, 119, 219, 222–23, 254, 257–58, 266, 298–99 and 329.

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response to mass shootings. The mass shooting of so many randomly killed and wounded concert-goers, making this the most heinous episode of mass violence based on sheer numbers of victims, could seemingly only be the product of a malfunctioning brain. But Paddock's autopsy revealed no organic irregularities, unlike the autopsy done on Charles Whitman half a century earlier[473] or the scan of Herbert Weinstein's brain, ruled admissible at trial by the New York court on the charge of murdering his wife.[474]

With respect to the possibility that a mass murderer's act of violence may be attributable to such defects, the medical evidence remains insufficient to draw clear conclusions about causation. Actual disclosure of threatened violence is critical to the mental health professional's discharge of a *Tarasoff*-like duty to warn or otherwise protect third persons from injury by their patients. They typically cannot prevent dangerous patients from committing mass shootings or other acts of mass violence in the absence of the data necessary to draw such predictive conclusions.

A. Disclosure of a Threat to Commit an Act of Mass Violence

Even when suspected terrorists, whether international or domestic, have been identified by law enforcement prior to their commission of acts of mass violence, the information has apparently often not been sufficiently precise in terms of target or timing to facilitate prevention in the episodes of mass shooting detailed here. But, certainly, other planned acts of mass violence have been frustrated by law

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[473] PRESS CONFERENCE, REPORT TO THE GOVERNOR, MEDICAL ASPECTS, CHARLES J. WHITMAN CATASTROPHE (Sept. 8, 1966).

[474] 591 N.Y.S.2d 715, 723 (N.Y. Sup. Ct. 1992). The New York court held that evidence of apparent brain damage suffered by defendant charged with murder of his wife based on a PET scan would be admissible at trial:

> Defense counsel intends to call at trial a psychiatrist to testify that at the moment Weinstein allegedly killed his wife, he lacked the cognitive ability to understand the nature and consequences of his conduct or that his conduct was wrong. The psychiatrist is prepared to testify that Weinstein's cognitive power was impaired at that instant, in part, by organic brain damage.

Id. at 723. For more on admission of PET scans at trial, see Susan Rushing, *The Admissibility of Brain Scans in Criminal Trials: The Case of Positive Emission Tomography*, 50 COURT REV. 62 (2013), https://neuroethics.upenn.edu/wp-content/uploads/2013/08/CR50-2Rushing.pdf. The author is a member of the University of Pennsylvania faculty and holds both an M.D. (Yale) and J.D. (Stanford).

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enforcement when discovered through intelligence operations, perhaps most of which have never been disclosed to the public.[475]

Similarly, even when acts of violence might be anticipated with greater certainty, the mental health professional's duty to warn or protect could be expected to prevent a mass shooting or other mass violent act only when the therapist has had sufficient experience with the dangerous individual to draw a firm conclusion that warning or other protective acts, such as emergency hospitalization, are necessary and appropriate. The mischaracterization of motivations of mass shooters as "mental illness" is not only simplistic but suggests a deliberate attempt to focus attention on factors other than the availability of semi-automatic weapons, principally assault rifles, that afford the shooter the tool of choice for random or targeted shootings of multiple victims.

B. Mental Illness v. Access to Firearms: The Politics of Mass Shootings

Public health experts tend to focus on access to weapons as the key factor in broader issues of gun violence in the United States; mental health professionals are particularly concerned with "scapegoating" the mentally ill as inherently *dangerous* within the population, complicating funding for more treatment.[476] From their perspective, the emphasis on mental illness rather than control of weapons commonly used in the commission of mass shootings is problematic because, while there is widespread, but inconsistent, public support for firearms regulation,[477] there

[475] For a history of terrorist attacks known to have been prevented since the attack on the World Trade Center in 2001, see *List of Unsuccessful Terrorist Plots in the United States Post-9/11*, WIKIPEDIA, https://en.wikipedia.org/wiki/List_of_unsuccessful_terrorist_plots_in_the_United_States_post-9/11 (last visited June 8, 2021). For discussion of the legal ramifications of public policy based on the strategy of preventing or intervening to prevent terrorist acts, see Robert M. Chesney, *Beyond Conspiracy: Anticipatory Prosecution and the Challenge of Unaffiliated Terrorism*, 80 S. CAL. L. REV. 225, 227 (2007) (noting problems posed by identification of suspected terrorists not affiliated with "Foreign Terrorist Organizations" previously listed by secretary of state).

[476] Jeffrey W. Swanson, E. Elizabeth McGinty, Seena Fazel & Vickie M. Mays, *Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research To Policy*, 25 ANNALS EPIDEMIOLOGY 366 (2015) [hereinafter *Mental Illness and Reduction of Gun Violence*], https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4211925/pdf/main.pdf. The lead author of this study, Jeffrey W. Swanson, Ph.D., is Professor of Psychiatry and Behavioral Science at Duke University School of Medicine. *Jeffrey Swanson*, DUKE PSYCHIATRY & BEHAV. SCI., https://psychiatry.duke.edu/faculty/jeffrey-w-swanson-ma-phd (last visited June 6, 2021).

[477] Research on public support for gun control demonstrates uneven results with some polls finding increasing support, particularly for mandatory background checks for gun buyers, particularly when proposed expanded regulation includes restricted access for individuals suffering from mental illness. *See, e.g.*, Domenico Montanaro, *Americans Largely Support Gun Restrictions To 'Do Something' About Gun*

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has been little national action in terms of implementing new regulations. At the same time, while mental illness provides the alternative explanation for these acts of mass violence, there has not been an increase in funding for mental illness research, identification, and treatment that would reflect a national will to address the problem.[478]

Mental health professionals typically contest the conclusion or suggestion that perpetrators of mass shootings act out of mental illness, while public attitudes often embrace the notion that acts of mass violence are products of mental illness.[479]

Violence, NPR (Aug. 10, 2019), https://www.npr.org/2019/08/10/749792493/americans-largely-support-gun-restrictions-to-do-something-about-gun-violence ("What is clear, from public opinion polling, is that Americans believe gun violence is a problem, and they support more restrictions on guns. . . . There is public support for universal background checks for gun purchases, extreme risk protection orders (also called red flag laws), gun licensing, assault-weapons bans and bans on high-capacity magazines. But many of these issues are hotly polarizing. While they mostly enjoy support from Democrats and independents, Republicans are not always on board."). *Contra* William A. Galston & Clara Hendrickson, *Getting Beyond the Myths: What Americans Really Think About Gun Control*, BROOKINGS INSTITUTION (Aug. 22, 2019), https://www.brookings.edu/blog/fixgov/2019/08/22/what-americans-really-think-about-mass-shootings-and-gun-legislation/ ("While support for 'stricter' gun laws has risen from its low of a decade ago, it remains below where it stood in the mid-1990s, the last time the federal government enacted such laws. In June of 1995, for example, just 35 percent of Americans were more concerned that the federal government would go too far, 10 points below today's level, while 58 percent were more concerned that the government wouldn't do enough, 8 points above the most recent reading.").

[478] *See, e.g.*, *Position Statement 72: Violence: Community Mental Health Response*, MENTAL HEALTH AMERICA (Sept. 2018), https://www.mhanational.org/issues/position-statement-72-violence-community-mental-health-response. This interest group opposing increasing reliance on emergency or involuntary hospitalization as a means of preventing violence, noting:

> [M]aking it easier to commit people for involuntary mental health treatment will do little or nothing to prevent violent acts. It will only scare people from seeking help voluntarily and fail to increase the number who are committed. The premise that we can predict or prevent violent acts is unsupported. Even in the case of severe mental illnesses, mental health professionals possess no special knowledge or ability to predict future dangerous behavior.
> Paradoxically, making it easier to commit people to treatment will not lead to more commitments or more people getting care. A chronically underfunded mental health system, which experienced $4.6 billion in state budget cuts between 2009 and 2014, does not have the capacity to meet those needs.

Id.

[479] Matthew E. Hirschtritt & Renee Binder, *A Reassessment of Blaming Mass Shootings on Mental Illness*, 75 JAMA PSYCHIATRY 311, 311 (2018), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2673380. The authors, Professors of Psychiatry at the University of California San Francisco Medical School explain in the Abstract:

> Several recent mass shootings in the United States have prompted calls to address untreated serious mental illness. This rhetoric—delivered by policy

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Researchers reviewing the 1990 survey conducted by the National Institute of Mental Illness Epidemiological Catchment Area (ECA)[480] regarding perceptions of violence observed:

> The ECA study thus debunked claims on both extremes of the debate about violence and mental illness—from the stigma-busting advocates on the one side who insisted that mental illness had no intrinsic significant connection to violence at all, and from the fearmongers on the other side who asserted that the mentally ill are a dangerous menace and should be locked up; both views were wrong. The facts showed that people with serious mental illnesses are, indeed, somewhat more likely to commit violent acts than people who are not mentally ill, but the large majority are *not* violent toward others. Moreover, when persons with mental illness do behav[e] violently, it is often—although not always—for the same reasons that non-mentally ill people engage in violent behavior. In short, violence is a complex societal problem that is caused, more often than not, by other things besides mental illness.[481]

This analysis suggests the political and ideological problems that complicate the assessment of the role of mental illness in mass violence. For those who are particularly supportive of the right to possess firearms, the concern that mass shootings could result in increased regulation of acquisition or ownership of firearms is evident, particularly in the increased public response favoring regulation following mass shooting events, such as the Sandy Hook school shooting in Newtown,

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> makers, journalists, and the public—focuses the blame for mass shootings on individuals with serious mental illness (specifically, schizophrenia and psychotic spectrum disorders, bipolar disorder, and major depressive disorder), with less attention paid to other contributory factors, such as access to firearms.[1] Furthermore, attributing mass shootings to untreated serious mental illness stigmatizes an already vulnerable and marginalized population, fails to identify individuals at the highest risk for committing violence with firearms, and distracts public attention from policy changes that are most likely to reduce the risk of gun violence.

Id.

[480] *See, e.g.*, Karen H. Bourdon, Donald S. Rae, Ben Z. Locke, William E. Narrow & Darrel A. Regier, *Estimating the Prevalence of Mental Disorders in U.S. Adults from the Epidemiologic Catchment Area Survey*, 107 PUB. HEALTH REPS. 663, 663 (2007), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1403718/ ("The National Institute of Mental Health Epidemiologic Catchment Area Survey is a comprehensive, community-based survey of mental disorders and use of services by adults, ages 18 and older.").

[481] *Mental Illness and Reduction of Gun Violence*, *supra* note 476, at 368.

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Connecticut.[482] Opponents of more regulation of firearms have thus far prevailed in the legislative arena, however, as Democratic strategists and an editorial writer for the *Washington Post* explained in their 2019 op-ed:

> Like a director yelling "action," the horrific mass shootings in El Paso and Dayton, Ohio, last weekend cued all the same political actors to repeat all the same political lines. Conservatives offered their prayers and talked about mental health and video games; progressives decried inaction in Washington. Voters could be forgiven for assuming they have seen this play before and nothing will ever change. But this is wrong.
>
> America's relationship with guns *is* changing, and people, more than ever, want someone to "do something."[483]

Despite their reference to polling showing increased support for regulation, the authors concede that the major bipartisan effort to require more extensive background checks for purchasers of firearms, the Manchin/Toomey bill, was defeated by Republicans and red-state Democrats.[484]

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[482] *See, e.g.*, Colleen L. Barry, Emma E. McGinty, Jon S. Vernick & Daniel W. Webster, *After Newtown—Public Opinion on Gun Policy and Mental Illness*, 368 NEW ENGLAND J. MED. 1077 (2013), https://www.nejm.org/doi/full/10.1056/NEJMp1300512. These researchers conducted two surveys following the Sandy Hook mass shooting event focusing on public attitudes toward gun regulation and mental illness. They concluded:

> Findings from these surveys indicate high support among Americans—including gun-owners, in many cases—for a range of policies aimed at reducing gun violence. Gun policies with the highest support included those related to persons with mental illness. The majority of Americans apparently also support increasing government spending on mental health treatment as a strategy for reducing gun violence. Given the data on public attitudes about persons with mental illness, it is worth thinking carefully about how to implement effective gun-violence–prevention measures without exacerbating stigma or discouraging people from seeking treatment.

Id.

[483] Anna Greenberg, David Walker & Alex Nabaum, *America Is Turning Against Guns*, WASH. POST (Aug. 9, 2019), https://www.washingtonpost.com/outlook/2019/08/09/how-americans-are-supporting-gun-control-wake-mass-shootings-like-el-paso/?arc404=true ("Even before the shootings in El Paso and Dayton, Gallup recorded the highest level of support for stricter gun laws in 25 years.").

[484] Aaron Blake, *Machin-Toomey Gun Amendment Fails*, WASH. POST (Apr. 17, 2013), https://www.washingtonpost.com/news/post-politics/wp/2013/04/17/manchin-toomey-gun-amendment-fails/.

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Opponents of more rigorous regulation of firearm access and ownership argue that mental illness is the primary factor in addressing mass shootings, opposing more firearms regulation, a position endorsed by President Trump.[485] It is not, however, a position exclusively held by President Trump. In an op-ed published by the *L.A. Times*, authors Grant Duwe and Michael Rocque referred to studies in which a significant number of perpetrators of mass shootings were believed to have suffered from mental illness. They noted:

> In a story that largely suggested mass murderers are not "insane," the New York Times cited research showing that, in fact, mass murderers are nearly *20 times* more likely to have a "severe" mental illness than the general population.
>
> According to our research, only one-third of the people who have committed mass shootings in the U.S. since 1900 had sought or received mental health care prior to their attacks, which suggests that most shooters did not seek or receive care they may have needed.
>
> This treatment gap is underscored by evidence showing that the U.S. has higher rates of untreated serious mental illness than most other Western countries. Additional research shows that the gap is even larger for males, who have committed 99% of the country's mass public shootings.[486]

They sought to rebut the argument that there is no link between mental illness and mass shootings: "According to our research, at least 59% of the 185 public mass shootings that took place in the United States from 1900 through 2017 were carried

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[485] *See supra* notes 4, 9, 11, 18 and accompanying text; *see also Mental Illness and Reduction of Gun Violence*, *supra* note 476, at 367, noting the tendency of public opinion to accept mental illness as a primary cause for mass violence:

> The public perception of a strong link between mental illness and violence is fueled in part by news coverage of mass shootings and other violent events. Two studies have directly linked news media coverage of high-profile acts of violence by persons with serious mental illness to negative public attitudes toward this group.

Id.

[486] Grant Duwe & Michael Rocque, *Op-Ed: Actually, There Is a Clear Link Between Mass Shootings and Mental Illness*, L.A. TIMES (Feb. 23, 2018), https://www.latimes.com/opinion/op-ed/la-oe-duwe-rocque-mass-shootings-mental-illness-20180223-story.html. Grant Duwe is research director for the Minnesota Department of Corrections and the author of MASS MURDER IN THE UNITED STATES: A HISTORY (2007). *Grant Duwe*, BAYLOR UNIVERSITY: ISR SCHOLARS, https://www.baylorisr.org/scholars/d/grant-duwe/. Michael Rocque is a Professor of Sociology at Bates College. *Michael Rocque*, BATES: FACULTY EXPERTISE, https://www.bates.edu/faculty-expertise/profile/michael-rocque/.

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out by people who had either been diagnosed with a mental disorder or demonstrated signs of serious mental illness prior to the attack."[487]

C. Findings of the National Threat Assessment Center

The conclusion reached by Duwe and Rocque is consistent with findings of the Secret Service National Threat Assessment Center in its published reports on Mass Attacks in Public Spaces, surveying attacks occurring in 2017,[488] 2018,[489] and 2019.[490] In its study of twenty-eight mass attacks (twenty-three of which involved the use of firearms) occurring from January through December 2017, the Secret Service found that the relationship of mental disturbance to violent acts was significant:

> MENTAL HEALTH: Nearly two-thirds of the attackers (n = 18, 64%) experienced mental health symptoms prior to their attacks. The most common symptoms observed were related to psychosis (e.g., paranoia, hallucinations, or delusions) and suicidal thoughts. Further, some attackers (n = 7, 25%) had been hospitalized for treatment or prescribed psychiatric medications prior to their attacks.[491]

For calendar year 2018, the threat assessment reported twenty-seven incidents concluding:

> Regardless of whether these attacks were acts of workplace violence, domestic violence, school-based violence, or inspired by an ideology, similar themes were observed in the behaviors and circumstances of the perpetrators, including:

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[487] *Id.*

[488] U.S. DEP'T OF HOMELAND SECURITY: NAT'L THREAT ASSESSMENT CTR., MASS ATTACKS IN PUBLIC PLACES—2017 (2018), https://www.secretservice.gov/sites/default/files/reports/2020-09/USSS_FY2017_MAPS.pdf [hereinafter 2017 Threat Assessment].

[489] U.S. DEP'T OF HOMELAND SECURITY: NAT'L THREAT ASSESSMENT CTR., MASS ATTACKS IN PUBLIC PLACES—2018 (2019), https://www.secretservice.gov/sites/default/files/2020-04/USSS_FY2019_MAPS.pdf [hereinafter 2018 Threat Assessment] (The Secret Service identified 27 mass attacks occurring during 2018.).

[490] U.S. DEP'T OF HOMELAND SECURITY: NAT'L THREAT ASSESSMENT CTR., MASS ATTACKS IN PUBLIC PLACES—2019 (2020), https://www.secretservice.gov/sites/default/files/reports/2020-09/MAPS2019.pdf [hereinafter 2019 Threat Assessment].

[491] 2017 Threat Assessment, *supra* note 488.

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- Most of the attackers utilized firearms, and half departed the site on their own or committed suicide.
- Half were motivated by a grievance related to a domestic situation, workplace, or other personal issue.
- *Two-thirds had histories of mental health symptoms, including depressive, suicidal, and psychotic symptoms.*
- Nearly all had at least one significant stressor within the last five years, and over half had indications of financial instability in that timeframe.
- Nearly all made threatening or concerning communications and more than three-quarters elicited concern from others prior to carrying out their attacks. The violence described in this report is not the result of a single cause or motive. The findings emphasize, however, that we can identify warning signs prior to an act of violence.[492]

For 2019, the Secret Service reported on 34 incidents in its most recent Threat Assessment:

> The study examines 34 incidents of mass attacks—in which three or more people, not including the attacker(s), were harmed—that were carried out by 37 attackers in public spaces across the United States between January and December 2019. In total, 108 people were killed and an additional 178 people were injured. The findings from this report offer critical information that can aid in preventing these types of tragedies, and assist law enforcement, schools, businesses, and others in the establishment of appropriate systems to recognize the warning signs and intervene appropriately. Key findings from this analysis include:
>
> - The attacks impacted a variety of locations, including businesses/workplaces, schools, houses of worship, military bases, open spaces, residential complexes, and a commercial bus service.
> - Most of the attackers used firearms, and many of those firearms were possessed illegally at the time of the attack.
> - Many attackers had experienced unemployment, substance use or abuse, mental health symptoms, or recent stressful events.
> - Attackers often had a history of prior criminal charges or arrests and domestic violence.
> - Most of the attackers had exhibited behavior that elicited concern in family members, friends, neighbors, classmates, co-workers, and others, and in many cases, those individuals feared for the safety of themselves or others.

[492] 2018 Threat Assessment, *supra* note 489.

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> These violent attacks impacted a variety of community sectors and were perpetrated by individuals from different backgrounds and with varying motives. *However, similar to previous Secret Service research, common themes were observed in the behaviors and situational factors of the perpetrators, including access to weapons, criminal history, mental health symptoms, threatening or concerning behavior, and stressors in various life domains.*[493]

In its 2020 report, the National Threat Assessment Center explains that its research is designed to address the threat of mass violence by enabling a number of actors to recognize potential threats, including mental health professionals and law enforcement officers, who play "play a significant role in the multidisciplinary team approach that is the foundation of the field of threat assessment."[494]

D. Threat Assessments: Mental "Illness" as a Causation Factor

While some perpetrators may suffer from recognized mental illnesses, such as bipolar I disorder, depression, or schizophrenia, it is difficult to assess whether the act of mass violence was actually triggered by illness rather than associated with a personality disorder such as paranoia, narcissism,[495] and antisocial personality disorder, commonly referred to as psychopathy or sociopathy.[496] Similarly, the substantial presence of mental disorders in American society may serve to question whether it is an underlying mental illness or personality disorder that causes an individual to commit an act of mass violence or that some individuals suffering from mental disturbance may act under the influence of particular stressors. The Secret Service survey of acts of mass violence committed in 2017 addressed apparent

[493] 2019 Threat Assessment, *supra* note 490, at 8–9. The report on 2019 incidents specifically found: "Most of the attacks (*n* = 24, 71%) involved the use of one or more firearms, which included rifles, handguns, and a shotgun." *Id.* at 9.

[494] *Id.* at 4.

[495] The report prepared by the Secret Service National Threat Assessment Center, reported that "Aggressive Narcissism" was a common personality character trait in perpetrators of acts of mass violence: "Most of the attackers (*n* = 23, 82%) exhibited behaviors that were indicative of aggressive narcissism, as evidenced by displays of rigidness, hostility, or extreme self-centeredness." 2017 Threat Assessment, *supra* note 488, at 5.

[496] *See, e.g.*, Marcia Purse, *How Sociopaths Are Different from Psychopaths*, VERYWELL MIND (June 15, 2020), https://www.verywellmind.com/what-is-a-sociopath-380184 ("While psychopaths are classified as people with little or no conscience, sociopaths do have a limited, albeit weak, ability to feel empathy and remorse. Psychopaths can and do follow social conventions when it suits their needs. Sociopaths are more likely to fly off the handle and react violently whenever they're confronted by the consequences of their actions.").

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evidence of psychological stressors as prevalent in the lives of perpetrators of acts of mass violence:

> All of the attackers had at least one significant stressor occur in their lives in the five years leading up to the attack. For some, this was in addition to any legal consequences they may have been dealing with related to the charges described above. These additional stressors most often related to:
>
> - Family/romantic relationships, such as spousal estrangements, divorces, romantic breakups, rejected proposals, physical or emotional abuse, or the death of a parent ↔ Personal issues, such as unstable living conditions, physical illnesses, or other significant disorders
> - Work or school environments, such as being fired or suspended, filing grievances, being bullied at work or at school, feeling disrespected, or being the subject of real or perceived gossip
> - Contact with law enforcement that did not result in arrests or charges, such as being the subject of domestic disturbance calls or being sought for a crime unrelated to their attack.
>
> Beyond these areas, we found that over half of the attackers (n = 16, 57%) experienced stressors related to financial instability in the five-year period prior to their attacks. These financial stressors included an inability to maintain employment; living in homeless shelters; failed business ventures; and civil court filings and proceedings, such as judgments, evictions, tax warrants, and wage garnishments. For 10 of the attackers, these stressors occurred within one year of the attack.[497]

Moreover, the commission of an act of mass violence itself is likely to result in a diagnosis of antisocial personality disorder or psychopathy, rather than mental illness, although concurrent diagnoses are likely. However, the public is generally responsive to the suggestion that mental illness must be at the heart of what are essentially irrational acts of mass violence.[498]

The researchers involved in a National Institutes of Health (NIH) study directed by Duke Medical School Professor Jeffrey Swanson explained:

> For their part, mental health stakeholders [have] encountered a painful dilemma. The goal of keeping guns out of the hands of seriously mentally ill

[497] 2017 Threat Assessment, *supra* note 488, at 5.

[498] *Mental Illness and Reduction of Gun Violence*, *supra* note 476, at 367. The authors of the NIH study note: "Negative public attitudes toward persons with serious mental illnesses such as schizophrenia and bipolar disorder are pervasive and persistent in the United States, and the assumption of dangerousness is a key element of this negative stereotype." *Id.*

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> individuals was emerging as perhaps the only piece of common ground between gun rights and gun control proponents; a post-Newtown public opinion poll found that a majority of Americans across the political spectrum favored "increasing government spending to improve mental health screening and treatment as a strategy to prevent gun violence." But mental health experts and consumer advocates strongly rejected what they saw as the scapegoating of people with mental illnesses—the vast majority of whom, epidemiologic data shows, will never act violently toward others—as if people with mental health disorders were somehow responsible for gun violence in general. These stakeholders thus faced the difficult prospect of debunking the public perception that "the mentally ill are dangerous," while attempting to leverage that very perception to build support for (much-needed) public funding to improve the mental health care system in the United States—and to achieve this goal without also spawning crisis-driven laws that might overreach in restricting the rights and invading the privacy of people with mental illnesses.[499]

Another NIH sponsored study offered a similar conclusion in focusing on access to weapons as the more appropriate policy concern for prevention of mass shootings, rather than resting policy on mental illness as a cause of mass violence:

> It is undeniable that persons who have shown violent tendencies should not have access to weapons that could be used to harm themselves or others. However, notions that mental illness caused any particular shooting, or that advance psychiatric attention might prevent these crimes, are more complicated than they often seem.[500]

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[499] *Id.* at 366–67.

[500] Jonathan M. Metzl & Kenneth T. MacLeish, *Mental Illness, Mass Shootings, and the Politics of American Firearms*, 105 AM. J. PUB. HEALTH 240, 240 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4318286/pdf/AJPH.2014.302242.pdf. The authors examine changing attitudes toward gun control based upon racial attitudes, perhaps oddly, noting that in the 1960s and 70s concern focused in public discussion on fear that African Americans would become armed, following Black political leaders:

> Recent history thus suggests that cultural politics underlie anxieties about whether guns and mental illness are understood to represent individual or communal etiologies. In the 1960s and 1970s, widespread concerns about Black social and political violence fomented calls for widespread reforms in gun ownership. As this played out, politicians, FBI profilers, and psychiatric authors argued for the right to use mental health criteria to limit gun access, not just to severely mentally ill persons, but also to "drunkards," "drug users," and political protesters. Building on these assumptions, the American

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VII. CONCLUSIONS: *TARASOFF* AND THE PROBLEM OF PREDICTING AND PREVENTING MASS SHOOTINGS

> *"I think mental health is the problem here," Trump said during a news conference in Tokyo, saying the shooter in Texas was a "deranged" man who should have received treatment. "This isn't a guns situation."*[501]

The unresolved discussion of the link between mental illness and crimes of mass violence[502] leaves the role of mental health professionals in the prediction and prevention of mass shootings and other acts not only unsettled, but overstated. Any expectation that expansion of the *Tarasoff* duty through judicial decisions or legislative action will address the problem of mass shootings in public spaces, as referenced by the Secret Service in the National Threat Assessment report, will almost certainly be frustrating for a number of obvious reasons:

● First, the most compelling flaw in expecting the mental health system to identify those individuals who might be candidates to commit acts of mass violence is that there is neither proof nor even consensus that these acts are actually products

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> Psychiatric Association later recommended that "strong controls be placed on the availability of all types of firearms to private citizens."

Id. at 245. In contrast, current support for gun ownership reflects a different perspective:

> However, in the present day, the actions of lone White male shooters lead to calls to expand gun rights, focus on individual brains, or limit gun rights just for the severely mentally ill. Indeed it would seem political suicide for a legislator or doctor to hint at restricting the gun rights for White Americans, private citizens, or men, even though these groups are frequently linked to high-profile mass shootings. Meanwhile, members of political groups such as the Tea Party who advocate broadening gun rights to guard against government tyranny—indeed the same claims made by Black Panther leaders in the 1960s—take seats in the US Congress rather than being subjected to psychiatric surveillance.

Id.

[501] David Jackson, *Trump: 'Mental Health' Is the Issue Behind the Texas Shooting, Not Guns*, USA TODAY (Nov. 6, 2017), https://www.usatoday.com/story/news/politics/2017/11/06/trump-mental-health-issue-behind-texas-shooting-not-guns/834879001.

[502] Jessica Duncan, *The Facts on Mental Illness and Mass Shootings*, FACTCHECK.ORG (Oct. 18, 2019), https://www.factcheck.org/2019/10/the-facts-on-mental-illness-and-mass-shootings/. Duncan is a science writer for FACTCHECK.ORG, and holds a Ph.D in immunology from Yale University. *See Our Staff*, FACTCHECK.ORG, https://www.factcheck.org/our-staff/.

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of mental illness. While perpetrators may suffer from mental illness, there is no evidence to establish that mental illness alone can explain their acts of mass violence.

● Second, the more likely psychological framework exhibited by perpetrators actually demonstrates the existence of serious personality disorders, including antisocial personality disorder, reflected in characterizations of the disorder as psychopathy or sociopathy.[503]

● Third, and perhaps most obvious, is that mental health providers will almost always only find it necessary to warn or act to protect potential victims when a patient or other person interacts with a mental health professional in a therapeutic relationship or under examination for purposes of diagnosis. It is in this kind of circumstance in which the potential perpetrator is likely to express a threat to commit a particular violent act, identify a target of violence, or at least, disclose tendencies to commit an act of violence such as a mass shooting. Many perpetrators of mass shootings may well have suffered from mental illnesses and certainly exhibited signs of personality disorders. There is little evidence of their contact with mental health professionals, however, in situations in which disclosure of threatened violence would have been likely, particularly since narcissistic, paranoid, or antisocial personality disorders would have probably led to the concealment of specific expressions of potential violence that once discovered could have led to confinement by involuntary hospitalization for evaluation and treatment.

● And, finally, there is clearly difficulty imposed by the *Tarasoff* duty in making an assessment of dangerousness warranting warning to third persons or acting to prevent injury whether individual targets of the dangerous patient have been disclosed or undertaking emergency hospitalization for the patient. Commenting on the Sandy Hook shooter,[504] who was known to have suffered from Asperger's syndrome,[505] Dr. Edward P. Mulvey described the perpetrator as "a withdrawn,

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[503] *See* notes 33, 501, for references to "psychopathy" and "sociopathy."

[504] Edward P. Mulvey, *Predicting Mass Killings Impossible*, CNN (Dec. 18, 2012), http://www.cnn.com/2012/12/18/opinion/mulvey-mental-disorder/index.html. Dr. Mulvey is Director of the Law and Psychiatry Program at the University of Pittsburgh Medical School. *Edward P. Mulvey, PhD*, U. PITT., http://www.hsalumni.pitt.edu/person/edward-p-mulvey-phd.

[505] Asperger's syndrome is a developmental disorder included on the autism spectrum typified by difficulties in social interaction. In 2013, the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) folded Asperger's syndrome under the umbrella of autism spectrum disorder (ASD). AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013). The relationship between Asperger's syndrome and violent behavior is apparently not conclusively established. *See* David S. Im, *Template to Perpetuate: An Update on Violence in Autism Spectrum*

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socially awkward young man, *reportedly* with Asperger's syndrome, living with his mother."[506] Dr. Mulvey then explained:

> We would like to think that if only professionals could identify any shooters before they commit any violence, then we could prevent these tragedies. If they had been locked up, then they couldn't have killed anyone. Or if they had been forced to take their medicine, then they wouldn't have gotten to a point of no return. If we can find these people, keep guns away from them, restrict their civil liberties and monitor them closely enough, then we would have solved the problem.
>
> This approach won't work. Hindsight is not foresight. The picture is much more complex than simply developing "profiles." Knowing this young man's

Disorder, 24 HARV. REV. PSYCHIATRY 14 (Jan. 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4710161/pdf/hvp-24-14.pdf. Dr. Im reports:

> For the past two decades, researchers have been using various approaches to investigate the relationship, if any, between autism spectrum disorder (ASD) and violence. The need to clarify that relationship was reinforced by the tragic mass shooting at Sandy Hook Elementary School in Newtown, Connecticut, in December 2012 by an individual diagnosed with Asperger's syndrome.
> Although some case reports have suggested an increased violence risk in individuals with ASD compared to the general population, prevalence studies have provided no conclusive evidence to support this suggestion. Among individuals with ASD, however, generative (e.g., comorbid psychopathology, social-cognition deficits, emotion-regulation problems) and associational (e.g., younger age, Asperger's syndrome diagnosis, repetitive behavior) risk factors have been identified or proposed for violent behavior.
> While no conclusive evidence indicates that individuals with ASD are more violent than those without ASD, specific generative and associational risk factors may increase violence risk among individuals with ASD.

Id. at 14. Dr. Im is Assistant Clinical Professor of Psychiatry at the University of Michigan Medical School. *See David S. Im, M.D*, MICH. MED.: DEP'T PSYCHIATRY, https://medicine.umich.edu/dept/psychiatry/david-s-im-md. While a direct relationship between Asperger's syndrome or other autism disorders and propensity for violence may never be demonstrated by research, the typical symptom of difficulties in social interaction experienced by sufferers might suggest the impact of stressors leading to violence noted in the National Threat Assessment Center reports documenting acts of mass violence. *See, e.g.*, *supra* note 488 and accompanying text. Problems associated with the syndrome itself could prove to be stressors influencing violent behavior, or symptoms could serve to exacerbate stress that could be successfully addressed but for the existence of those symptoms, causing escalation of anxiety to violence.

[506] Mulvey, *supra* note 504.

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> profile wouldn't have told us how likely he was going to walk into a classroom and open fire.[507]

What seems clear from this discussion is that neither mental health professionals nor the mental health system itself will afford general effectiveness in the prevention of acts of mass violence, even given expansion of the duty to warn or protect traced to *Tarasoff*. Nor will the availability of treatment of perpetrators be an answer to future mass violence because, in most episodes, the perpetrator is either killed by law enforcement, stopped by armed civilians intervening as occurred in the case of Sutherland Springs, or commits suicide. The death of the perpetrator deprives law enforcement officers investigating the episode of the opportunity to interview the single most important actor involved. It also deprives mental health professionals of the opportunity to investigate the perpetrator's motivation or mental state at the time of its commission, forcing review through a psychological autopsy, typically leading only to informed speculation.

However, two additional lines of inquiry might prove important in looking at mass shootings for future understanding. First, there was an obvious lull in the commission of mass shootings during 2020, the year in which the United States was gripped by the coronavirus pandemic.[508] It is likely that the reduction in the number of mass shootings is attributable, at least in part, to the sheltering policies that have resulted in fewer mass gatherings of people in public spaces.[509]

Thus, a possible unintended consequence of the national and local responses to the COVID-19 pandemic might have been thought to portend a decline in firearms violence or episodes of mass violence es, including particularly mass shootings. The resulting from enforcement of social distancing regulations imposed as emergency responses to the dramatic communicability of this coronavirus, and of self-enforcement through sheltering-in-place and social distancing protocols, reduced the occasion, or opportunity for mass public events. Logically, this resulted in some obvious reduction in opportunities for disturbed or ideologically inspired individuals to actually engage in acts of mass violence, including mass shootings, that could successfully target large numbers of individuals. However, to the extent that social

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[507] *Id.*

[508] Lisa Marie Pane, *In a Year of Pain, One Silver Lining: Fewer Mass Shootings*, ASSOCIATED PRESS (Dec. 29, 2020), https://apnews.com/article/us-news-pandemics-shootings-coronavirus-pandemic-052396ae1f5322397c04fd191f596190.

[509] *Id.*

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distancing is not only not enforced but attacked politically by those attending mass public events, COVID-19 did not necessarily provide any indirect protection against episodes of mass violence.[510] Nor did the pandemic apparently result in an overall reduction in firearms violence during the year and months of lockdown and forced isolation.[511]

With the recent easing of many limitations on public gatherings by states,[512] mass shootings in Atlanta, Georgia on March 16, 2021[513] and Boulder, Colorado, on

[510] *See, e.g.*, Alta Spells & Eliott C. McLaughlin, *At Least 2 Killed in a Shooting At a Greenville, South Carolina, Club, Police Say*, CNN (July 5, 2020), https://www.cnn.com/2020/07/05/us/greenville-south-carolina-shooting/index.html.CNN reported: "The nightclub was hosting a 'very, very, very, large crowd' for a concert when the shooting erupted, Greenville County Sheriff Hobart Lewis said." CNN further reported that there had not yet been any arrests, but that there were two suspected shooters, with no speculation about a motive for the shooting. It quoted the sheriff: "'There's a lot of shell casings inside,' Lewis said. 'Everything is turned over. There are a few chairs in there, food on the floor, some bottles busted. You can tell somebody left in a hurry. There are some pretty large amounts of blood.'" *Id.*

[511] *See, e.g.*, Reis Thebault, Joe Fox & Andrew Ba Tran, *2020 Was the Deadliest Gun Violence Year in Decades. So Far, 2021 Is Worse*, WASH. POST (June 14, 2021), https://www.washingtonpost.com/nation/2021/06/14/2021-gun-violence/. The Post reports:

> Through the first five months of 2021, gunfire killed more than 8,100 people in the United States, about 54 lives lost per day, according to a Washington Post analysis of data from the Gun Violence Archive, a nonprofit research organization. That's 14 more deaths per day than the average toll during the same period of the previous six years.
> This year, the number of casualties, along with the overall number of shootings that have killed or injured at least one person, exceeds those of the first five months of 2020, which finished as the deadliest year of gun violence in at least two decades.

Id.

[512] *See, e.g.*, Julie Bosman & Lucy Tomkins, *Texas Drops Its Virus Restrictions as a Wave of Reopenings Takes Hold*, N.Y. TIMES (Mar. 2, 2021), https://www.nytimes.com/2021/03/02/us/coronavirus-reopening-texas.html.

[513] *8 Dead in Atlanta Spa Shootings, With Fears of Anti-Asian Bias*, N.Y. TIMES (Mar. 17, 2021), https://www.com/live/2021/03/17/us/shooting-atlanta-acworth (updated Mar. 26, 2021).

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March 26, 2021[514] highlighted an uptick in acts of mass violence for that month.[515] These shootings clearly suggest that a conclusion of the pandemic will not result in a departure from the pattern of regular episodes of mass shootings resulting in significant loss of life and injuries sustained by shooting victims. They have renewed concerns over gun violence and control of firearms.[516]

Two very important concerns around the return to regular episodes of mass shootings are illustrated, moreover, by the attack on employees of the FedEx Ground facility in Indianapolis on April 15, 2021. First, the motive of the 19-year-old perpetrator, a former short-term employee at the facility, remains in doubt, but the suspect had been identified by federal agents in 2020 and placed under a "mental

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[514] Kate Brumback & Angie Wang, *Man Charged With Killing 8 People at Georgia Massage Parlors*, ASSOCIATED PRESS (Mar. 17, 2021), https://apnews.com/article/georgia-massage-parlor-shootings-leave-8-dead-f3841a8e0215d3ab3d1f23d489b7af81. Six women of Atlanta's Asian-American community were among the eight victims killed in the series of assaults committed by the suspect who told police that he suffered from a *sex addiction* apparently causing his rampage. With respect to this explanation, arguably explaining that the motivation for the mass shooting was not the result of ethnic hatred, the authors noted:

> The American Psychiatric Association does not recognize sex addiction in its main reference guide for mental disorders. While some people struggle to control their sexual behaviors, it's often linked to other recognized disorders or moral views about sexuality, said David Ley, clinical psychologist and author of "The Myth of Sex Addiction."

Id.

[515] *See, e.g.*, Madeline Holcombe & Dakin Andone, *The US Has Reported At Least 50 Mass Shootings Since the Atlanta Spa Shootings*, CNN (Apr. 20, 2021), https://www.cnn.com/2021/04/18/us/mass-shootings-since-march-16/index.html. This report references the significant number of mass shootings reported in the United States following the Atlanta massage parlor shootings on March 16, 2021.

[516] Christal Hayes, *'Why Does This Keep Happening?' Mass Shootings in Boulder and Atlanta Expose Loopholes, Weaknesses in Gun Laws*, USA TODAY (Apr. 1, 2021), https://www.usatoday.com/story/news/nation/2021/04/01/mass-shootings-georgia-colorado-expose-lax-gun-laws-amid-cries-reform/7061512002/. The report focused on acquisition of firearms by perpetrators of the Atlanta and Colorado mass shootings:

> The suspect who police said opened fire and killed eight at three spas in Georgia—an attack that shook the Asian American community—bought a handgun hours before the massacre. Georgia has no state law requiring a firearm waiting period, a requirement in 10 states and the District of Columbia that aims to save lives by delaying a potential killer from acting on impulse.
> Six days after the Georgia assault, police said, a man described by family members as mentally ill attacked a Colorado grocery store and killed 10, including an officer. Police said that in the days before the attack, the suspect purchased a Ruger AR-556 pistol that experts said largely mirrors a short-barrel rifle.

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health temporary hold" by Indianapolis police.[517] But, concern was raised within the Sikh community because four of the eight victims killed in the assault were members of that community.[518] Second, although the suspect's firearm had previously been seized but was not forfeited under Indiana's "red flag" law, it had been returned to him. As a result, he had been able to purchase two semi-automatic rifles lawfully in July and October 2020, after being temporarily detained.[519] While the perpetrator's death may ultimately prove to frustrate any accurate assessment of his motivation, the circumstances of the FedEx shooting illustrate the multiple problems posed for prevention of mass shootings even when indications of mental impairment suggesting potential for violence are known to law enforcement authorities and weaknesses inherent in regulation of access to weapons most likely to be used in such episodes fail to deter the ultimate act of mass violence.

Moreover, it is also clear that if the public isolation that has resulted from policies limiting public gatherings and activities has resulted in some lessening of the most dramatic and consequential episodes of mass violence, there has also been an increase in domestic violence.[520] The increase in domestic violence is straining public resources for assisting victims:

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[517] Steve Almasy, Jason Hanna & Amanda Watts, *Police ID Gunman Who Killed 8 People at an Indianapolis FedEx Facility as 19-year-old Former Employee*, CNN (Apr. 17, 2021), https://www.cnn.com/2021/04/16/us/indianapolis-shooting-fedex-facility/index.html.

[518] Nora Naughton & Laura Kusisto, *FedEx Shooting Probe Centers on Motives, Gun Purchases*, WALL ST. J. (Apr. 18, 2021), https://www.wsj.com/articles/in-fedex-shooting-gun-purchases-motives-under-investigation-11618758394.

[519] *Id.*

[520] *See, e.g.*, Andrew M. Campbell, *An Increasing Risk of Family Violence During the Covid-19 Pandemic: Strengthening Community Collaborations to Save Lives*, FORENSIC SCI. INT'L 1 (Apr. 12, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152912/pdf/main.pdf, observing:

> With shelter in-place measures and widespread organizational closures related to Covid-19 likely to continue for an extended period of time, stress and associated risk factors for family violence such as unemployment, reduced income, limited resources, and limited social support are likely to be further compounded.
> . . .
> An increasing risk of domestic violence-related homicide is also a growing concern—reports continue to surface around the globe of intimate partner homicides with ties to stress or other factors related to the Covid-19 pandemic. Reports of increasing gun and ammunition sales in the U.S. during the crisis are particularly concerning given the clear link between firearm access and fatal domestic violence incidents.

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> The coronavirus has created new tensions. Staying at home has worsened abusive situations. Shelters worry about the spread of the virus. Americans have been cooped up at home for months to slow the spread of the coronavirus, many of them living in small spaces, reeling from sudden job losses and financial worries. Children are home from school in every state in the country.
>
> That confinement has led to another spiraling crisis: Doctors and advocates for victims are seeing signs of an increase in violence at home. They are hearing accounts of people lashing out, particularly at women and children.
>
> "No one can leave," Kim Foxx, the chief prosecutor in Chicago, said in an interview. "You're literally mandating that people who probably should not be together in the same space stay."
>
> The problems have only deepened since stay-at-home orders were first imposed.[521]

An interesting consequence of the pandemic in this respect may well be whether the decline in mass violence would be reversed as the population returns to a pre-pandemic state with respect to public life. The increased vigilance in public places, including schools, retail establishments, and social entertainment venues such as restaurants, bars, theaters, and recreational areas could carry over as circumstances for social interaction return to what is often referred to as *normal* could influence public behavior enhancing security that could have frustrated perpetrators of mass violence and reduce episodes, but recent evidence does not support this speculation.

The speculation would have been predicated, at least in part, on the unproved suggestion that episodes of mass violence, particularly mass shootings, might be attributed to factors in which press coverage and comments influence other disaffected individuals to commit similar acts.[522] A decline in highly publicized episodes of mass shootings could theoretically have resulted in an overall reduction in mass violence. Researchers addressing the process of "imitation,"[523] have

[521] Julie Bosman, *Domestic Violence Calls Mount as Restrictions Linger: 'No One Can Leave,'* N.Y. TIMES (May 15, 2020), https://www.nytimes.com/2020/05/15/us/domestic-violence-coronavirus.html.

[522] James N. Meindl & Jonathan W. Ivy, *Mass Shootings: The Role of the Media in Promoting Generalized Imitation*, 107 AM. J. PUB. HEALTH 368 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5296697/pdf/AJPH.2016.303611.pdf. James N. Meindl is Associate Professor of Applied Behavior Analysis, University of Memphis. *See ICL Faculty*, U. MEMPHIS, https://www.memphis.edu/icl/faculty/. Jonathan W. Ivy is Assistant Professor of Psychology, Penn State Harrisburg and Professor-in-Charge, Master in Applied Behavior Analysis. *See Jonathan W. Ivy, Ph.D.*, PENNSTATE HARRISBURG, https://harrisburg.psu.edu/faculty-and-staff/jonathan-w-ivy.

[523] *Id.*

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concluded that, with respect to mass shooters, media coverage of mass shootings is important in influencing commission of other mass shootings:

> Importantly, the way that the media report an event can play a role in increasing the probability of imitation. When a mass shooting event occurs, there is generally extensive media coverage. This coverage often repeatedly presents the shooter's image, manifesto, and life story and the details of the event and doing so can directly influence imitation.[524]

It could ultimately be that the reordering of social interaction during the pandemic would result in a reduction in incidents of mass violence even after the conclusion of policies designed to enforce social distancing because the lack of press coverage of mass shootings will reduce the influence of mass acts in precipitating copycat shootings. Or, it could be that the end of the social-distancing policy will eventually recreate circumstances ripe for mass violence in public spaces. The unresolved questions raised by the social conditions dictated by the pandemic cannot, of course, be answered until some point in the future, but recent history suggests that the response to the pandemic will not contribute to any reduction in mass shootings or firearms violence in the United States.

However, a second issue that might well bear on the problem of preventing mass shootings and other episodes of mass violence warrants consideration. This arises from evidence of the significantly greater number of violent acts involving firearms that are committed in the United States than in other countries. In an editorial op-ed, *New York Times* reporters Max Fisher and Josh Keller referred to data pointing out the high level of violence associated with crime in the United States in addressing the problem of mass shootings. They initially noted: "America's gun homicide rate was 33 per million people in 2009, far exceeding the average among developed countries. In Canada and Britain, it was 5 per million and 0.7 per million, respectively, which also corresponds with differences in gun ownership."[525] The authors draw the link between gun ownership and mass shootings by rejecting other explanations:

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[524] *Id.* at 369.

[525] Max Fisher & Josh Keller, *What Explains U.S. Mass Shootings? International Comparisons Suggest an Answer*, N.Y. TIMES (Nov. 7, 2017, 11:41 A.M.), https://www.nytimes.com/2017/11/07/world/americas/mass-shootings-us-international.html.

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> But there is one quirk that consistently puzzles America's fans and critics alike. Why, they ask, does it experience so many mass shootings?
>
> Perhaps, some speculate, it is because American society is unusually violent. Or its racial divisions have frayed the bonds of society. Or its citizens lack proper mental care under a health care system that draws frequent derision abroad.[526]

They then conclude that mental illness cannot explain the substantially higher numbers of mass shootings in the United States, for instance.[527] Instead, they focus on gun ownership within a population as the key factor:

> These explanations share one thing in common: Though seemingly sensible, all have been debunked by research on shootings elsewhere in the world. Instead, an ever-growing body of research consistently reaches the same conclusion.
>
> The only variable that can explain the high rate of mass shootings in America is its astronomical number of guns.[528]

Whether other explanations than gun ownership have actually been "debunked" is debatable, and Fisher and Keller overlook the obvious question in stressing ownership as the responsible factor for mass shootings. That is: What explains the substantially greater ownership of guns by Americans than other populations?

Widespread ownership of guns by Americans does not, in itself, explain why those weapons are used in the commission of acts of mass violence. Moreover, there is absolutely no support for any suggestion that the federal and state governments could undertake a program of weapons reduction, whether voluntary buy-backs or involuntary seizures, that could successfully result in a significant reduction in the aggregate number of weapons. Only the paranoid speculation by elements of the population opposing all government regulation of firearms ownership or acquisition

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[526] *Id.*

[527] *Id.* ("A 2015 study estimated that only 4 percent of American gun deaths could be attributed to mental health issues.") (*Mental Illness and Reduction of Gun Violence*, *supra* note 476). They also relied on research by Dr. Adam Lankford, Professor of Criminology and Criminal Justice at the University of Alabama and his findings with respect to incidence of mass shootings. See *Adam Lankford*, U. ALA., https://cj.ua.edu/people/adam-lankford/; *see, e.g.*, Adam Lankford, *Public Mass Shooters and Firearms: A Cross-National Study of 171 Countries*, 31 VIOLENCE VICTIMS 187 (2016), https://pubmed.ncbi.nlm.nih.gov/26822013/#affiliation-1.

[528] Fisher & Keller, *supra* note 525.

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would even manufacture such a conspiracy, despite former Texas Democratic Representative and candidate for the 2020 Democrat presidential nomination Beto O'Rourke's claim: "Hell yes we're going to take your AR-15," made in the wake of the El Paso Walmart mass shooting in August, 2019.[529]

What cannot be denied is that the history of the United States is one of violence and racial discrimination. To dismiss these factors in assessing the country's character ignores that the actualization of its Manifest Destiny in the policies of genocide and racial discrimination reflected in the wars against native populations and legal slavery. It is possible that there is a flaw in the American character that reflects its violent past, a past born out of conflict and conquest dominated by the prevalence of firearms.

Fisher and Keller cite a revealing array of statistical comparisons between the United States and other developed nations with respect to gun ownership and gun violence that certainly suggest that gun ownership is the determining factor in the higher incidence of gun violence. But their position that ownership explains mass shootings runs contrary to the evidence they rely on in arguing that the refusal to regulate firearms is the cause. For instance:

> In 2013, American gun-related deaths included 21,175 suicides, 11,208 homicides and 505 deaths caused by an accidental discharge. That same year in Japan, a country with one-third America's population, guns were involved in only 13 deaths.
>
> This means an American is about 300 times more likely to die by gun homicide or accident than a Japanese person. America's gun ownership rate is 150 times as high as Japan's. That gap between 150 and 300 shows that *gun ownership statistics alone do not explain what makes America different*.[530]

If, in this instance, they conclude that "gun ownership statistics alone do not explain what makes America different,"[531] the logical conclusion is that something in the American character, or a value shared by many in the American community, is more likely responsible for mass shootings than simply access to firearms. A tiny minority

[529] *Beto O'Rourke on Gun Control: 'Hell Yes We're Going To Take Your AR-15,'* NBC NEWS (Sept. 12, 2019), https://www.nbcnews.com/video/beto-o-rourke-hell-yes-we-re-going-to-take-your-ar-15-68832325641.

[530] Fisher & Keller, *supra* note 525 (emphasis added).

[531] *Id.*

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of individuals commit acts of mass violence, yet there is still a hesitance to regulate firearms more aggressively.[532] That hesitance suggests nothing less than a tolerance for violence, as they note in the conclusion of their essay:

> "In retrospect Sandy Hook marked the end of the US gun control debate," Dan Hodges, a British journalist, wrote in a post on Twitter two years ago, referring to the 2012 attack that killed 20 young students at an elementary school in Connecticut. "Once America decided killing children was bearable, it was over."[533]

The end of the pandemic and relative normalization of social interactions, particularly in public spaces, will offer additional perspective on the factors that may be at the root of mass shootings. Regardless, understanding the motivations of perpetrators will likely have little impact on prevention given the likelihood that they will continue to die in the conclusion of their acts of mass violence, whether as a result of suicide or intervention by law enforcement or civilians, who will also be armed with firearms. What does seem clear is that the circumstances in which *Tarasoff* duties to warn or protect, regardless of their precise parameters within any given jurisdiction, will not prevent the overwhelming number of mass shootings even if prevention occurs in some cases. Even when mass shootings may be linked to mental illness or mental disturbance, the likelihood that perpetrators will themselves be linked to mental health evaluation or treatment would appear dim, at best.

EPILOGUE

The mass shooting at the FedEx distribution center in Indianapolis in April 2021, following the earlier episodes of mass violence in March in Atlanta, Georgia

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[532] Ironically, the Brookings Institution reports:

> The perceived threat of mass shootings by American citizens now dwarfs the threat of attacks by Islamist terrorists. 60 percent fear the former more than the latter; only 17 percent disagree. This holds true for Democrats and Republicans, liberals and conservatives, men and women, whites with and without a college degree, urban, suburban, and rural residents, and (by a margin of 53 percent to 23 percent) gun owners. But despite the urgency of this threat, only 15 percent of Americans, and fewer than one-third of Republicans, believe that the Trump administration has made the country safer from mass shootings.

Galston & Hendrickson, *supra* note 477.

[533] Fisher & Keller, *supra* note 525.

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and Boulder, Colorado, offers dramatic evidence that the relative silence in mass public violence during the COVID-19 pandemic will not prove to be a permanent cessation of these crimes. Instead, these very high profile episodes, coupled with the significant number of total mass shootings documented over the first months of 2021,[534] suggest quite the opposite—that public events of carnage caused by firearms will continue, at least in the foreseeable future. The FedEx shooting offered many of the most critical factual scenarios discussed in this Article, including:

> ● The fact that the perpetrator's death during the assault has left law enforcement without a definitive finding as to the cause for his actions. Recent investigation indicates that the shooter had accessed white supremacist political websites and was interested in a cultish fascination with "My Little Pony," associated with "Bronies,"[535] that suggests online involvement with extremist groups, often showing misogynist beliefs or tendencies;[536]
>
> ● The shootings occurred at the perpetrator's former workplace, or place of employment, a common feature of many mass shootings;[537]
>
> ● Four of the victims who were killed were members of the Sikh community in Indianapolis, raising the possibility that race or ethnic discrimination or religious discrimination was the motivation, or a factor, in the mass shooting;[538]
>
> ● The shooter, Brandon Hole, had previously interacted with local police in a dangerous situation in which his mother reported that he was threatening to commit suicide, pointing an unloaded shotgun at officers during a confrontation, with police seizing the weapon. During their investigation, police had found evidence that Hole visited white supremacist internet sites;[539]
>
> ● Because police had failed to invoke Indiana's "red flag law" following seizure of the shotgun, purportedly based on time constraints for developing evidence necessary to warrant seizure, Hole's shotgun had been returned to him

[534] *See supra* note 515.

[535] *See* Katie Shepherd, *FedEx Shooter Visited 'White Supremacist' Sites and Surrendered a Shotgun, but Didn't Trigger Red-Flag Law*, WASH. POST (Apr. 20, 2021), https://www.washingtonpost.com/nation/2021/04/20/indianapolis-shooter-white-supremacist-websites/. The shooter was believed to possibly be attracted to the "bronie subculture," according to sources: "Many 'Bronies' put on conventions, collect pony figurines, and celebrate the show in online message boards, but some pockets of the online community are rife with violent images and white supremacist rhetoric." *Id.*

[536] *See generally supra* notes 467–72 and accompanying text.

[537] *See supra* Section V.B.1.c.

[538] *See supra* notes 397, 518 and accompanying text.

[539] Shepherd, *supra*, note 535.

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and the law's provisions that would have prevented him from purchasing weapons lawfully permitted his purchase of two semi-automatic weapons months before the FedEx shooting;[540]

- The incident in which police had encountered Hole following the reported suicide threat led to a follow-up investigation by the FBI regarding his potential for committing a terrorist act.[541]

The FedEx shooting would appear to reflect precisely the set of circumstances that might trigger further investigation into the perpetrator's potential to commit a mass shooting. Prevention of the episode, however, would not appear to have necessarily impossible, given the large numbers of mentally ill and personality disordered individuals in this country, access to weapons, and availability of internet sites promoting politically or socially extreme viewpoints. Moreover, thus far, there is no evidence or indication that the shooter had been involved in mental health treatment or therapy in which he might have disclosed his intent or threat to commit an act of violence toward third persons that would have triggered a warning or other protective act by a mental health professional.[542]

Author's note: The discussion of mass shootings that have occurred in the United States during the writing of this Article essentially concludes with references to the Indianapolis FedEx shooting as a matter of necessity. The frequent recurrence of these episodes and their relevance to the issues addressed here has certainly slowed the writing and editing processes. Even in the final stages of editing, the workplace shooting at the Santa Clara Valley Transportation Authority terminal in San Jose, California[543] *on May 26 occurred, illustrating the difficulty in attempting a comprehensive discussion of these episodes in addressing the problems associated with mass shootings and expectations that expansion of the* Tarasoff *duty could reasonably be expected to end the recurring violence of mass shootings.*

This Article includes significant use of descriptive language regarding aberrant behavior serving to address mental state elements in the definition of crime, as well as descriptions of behavior or mental state relating to mental impairment or

[540] *Id.*

[541] *Id.*

[542] Under Indiana law, a mental health professional has a duty to warn an intended victim or appropriate law enforcement agencies or take precautionary measures, such as emergency civil commitment, designed to prevent patient violence toward a third person. IND. CODE § 34-30-16-2.

[543] *See, e.g.*, Jason Hanna, Josh Campbell & Amir Vera, *The San Jose Gunman Appeared To Specifically Target His Victims, Sheriff Says*, CNN (May 28, 2021), https://www.cnn.com/2021/05/27/us/san-jose-shooting-thursday/index.html.

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disorders, descriptive language that may be questioned as to accuracy by mental health professionals. Discussion of mental state is often difficult for the lawyer not trained in psychiatry or psychology and imprecision or complication in language may even lead to questions in litigation, as evident in Kansas v. Hendricks*, 521 U.S. 346, 359 (1997) ("[T]he States have, over the years, developed numerous specialized terms to define mental health concepts. Often, those definitions do not fit precisely with the definitions employed by the medical community."). Errors in descriptive language in this Article are attributable to the author only.*

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