Washington Law Review Online

Volume 92 Article 2

2017

Volk v. DeMeerleer: An Unprincipled Divorce of Dangerousness and the *Tarasoff* Duty to Protect

Jaclyn Greenberg

VOLK V. DEMEERLEER: AN UNPRINCIPLED DIVORCE OF DANGEROUSNESS AND THE *TARASOFF* DUTY TO PROTECT

Jaclyn Greenberg*

Abstract: Since its inception in *Tarasoff v. Regents of the University of the California*, the duty to protect third parties imposed on mental health professionals (MHPs) has been the subject of considerable scrutiny. Clinicians and legal scholars alike derided the original duty to protect "anyone foreseeable" as unworkable—undermining the therapeutic relationship and placing MHPs in the impossible position of having to predict their patients' violent future. Over time, case law and legislation narrowed the duty to something less problematic: a "duty to warn" identifiable victims who face imminent threat of serious harm. However, *Volk v. DeMeerleer*, reset the duty for Washington MHPs to its original expansiveness, and arguably broadened the basis for imposing the duty. The decision effectively marries the duty to the mere presence of a therapeutic relationship, and divorces it from a patient's dangerousness—the objective criteria this Article argues is an implicit and necessary component of the duty. Dangerousness is not only a reasonable basis upon which to trigger the duty to protect, it also embodies the crucial development in mental health law that a mentally ill person's rights cannot be curtailed absent due process. This Article argues that *Volk* effectively denies the need for objective criteria to trigger the duty and, as a result, is legally unsupportable as well as practically unworkable. Worst of all, *Volk* undermines the legalist approach to mental health laws which arose in response to the repugnant presumption that a mentally ill person necessarily threatens the public's safety. This Article first traces the rise of rights-based mental health laws and the role of dangerousness, as well as the origin of the duty to protect. Second, it reviews trends in the duty to protect case law and legislation to identify the implicit role that dangerousness played in limiting *Tarasoff*. It further reflects on how dangerousness, although flawed, represents the best option for mediating the tension between honoring the rights of mentally ill persons and protecting society. Finally, this Article sets out the facts and rulings of *Volk*, concluding with a call for legislative reform. Absent a course correction, the decision invites a return to the false notion that mentally ill persons are inherently dangerous.

INTRODUCTION

The American justice system has long struggled with how best to reconcile the rights of persons with mental illnesses and the need to protect society from the few persons whose illnesses make them dangerous to others. In the latter half of the twenty-first century, mental health laws have resembled a fast moving pendulum, swinging from a paternalistic, professional discretion-based model toward a legalist,

rights-based one which demands that intervention be objectively justified.[1] Nowhere is this more evident than in the civil commitment process: whereas once all that was required to hospitalize someone involuntarily was an expert belief in the "need for treatment," today most laws require a determination that the patient presents a danger to himself or others.[2] Due process does not permit intervention otherwise.[3] Meanwhile, mental health policy has moved swiftly toward providing the mentally ill with the "least restrictive" care possible.[4] In all, the legal system has recognized that persons suffering from mental illness are no less deserving of freedom from state interference than any others absent exceptional circumstances, namely a violent threat to others.

Tangled up with these developments is the mental healthcare system. It is the vehicle by which the state can realize its ambition to draw the appropriate line between honoring the autonomy of the mentally ill and intervening when necessary. The mental healthcare system—referring to psychiatry, psychology, social work and related fields, and those who practice in these areas—provides the basis for courts and other state actors to lawfully intervene in someone's life on the basis of their mental status. Mental health professionals, therefore, play a crucial dual role in society: treating our most mentally-disordered citizens while also evaluating their potential to endanger the public.[5] These professionals distinguish the ill from the ill *and* dangerous.

Since the mid-1970s, when the California Supreme Court released its landmark decisions, *Tarasoff v. Regents of University of California*,[6] the

---

* LLM Candidate, Center for Law, Science & Global Health, University of Washington. I would like to thank Taya Briley for introducing me to this important topic and Terry Price for his support in the preparation of this Article. All errors and omissions remain my own.

1. *See* Lawrence O. Gostin, *Contemporary Social Historical Perspectives on Mental Health Reform*, 10 J.L. & SOC'Y 47, 47–48 (1983).

2. *See* Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 66 CASE W. RES. L. REV. 657, 668–69 (2016).

3. O'Connor v. Donaldson, 422 U.S. 563 (1975).

4. *See* MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 1-2.1.1 (3d ed. 2016).

5. *See* Fay Anne Freedman, *The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?*, 11 U. PUGET SOUND L. REV 255, 256 (1988) (referring to these responsibilities as the "dual duty of protecting others, while effectively treating patients").

6. Referring to both *Tarasoff v. Regents of Univ. of Cal*, 529 P.2d 553 (Cal. 1974) (en banc) (creating a "duty to warn") and *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (Cal. 1976) (creating a "duty to protect"). As discussed below, the separate rulings of the two decisions are often conflated when they ought not to be. Unless otherwise stated, when this Article refers to *Tarasoff*, the reference is to the 1976 decision.

corollary to this awesome responsibility was a legal obligation—and source of liability—to protect third parties from a violent patient.[7] This "duty to protect" raised three broad questions: when is the duty triggered; to whom is the duty owed; how is the duty fulfilled. Over the last forty years, courts and lawmakers have answered these questions, sometimes more precisely than others. Today, the duty to protect most commonly arises when a patient threatens an identifiable victim; the duty is owed to the known or knowable victim; and appropriate action may include initiating commitment proceedings (voluntary or involuntary), informing the authorities or others, or warning the intended victim.[8]

Gruesome crimes, however, continue to spur litigation to test these boundaries—lest it appear that victims are without recourse. Consider the recent Washington State Supreme Court case, *Volk v. DeMeerleer*.[9] In *Volk*, a psychiatrist was sued after one of his outpatients killed his ex-girlfriend and one of her sons.[10] The victims' family alleged that the psychiatrist failed to protect the victims, although the patient never voiced any threats about them to the psychiatrist nor, for that matter, expressed any general homicidal ideations in the six years leading up to the crime.[11] The Court ruled that the psychiatrist owed a broad duty to protect "all foreseeable victims,"[12] effectively erasing the duty to warn "identifiable victims" developed by courts and state legislatures.

In this Article, I argue that *Volk*'s application of the duty to protect "anyone foreseeable" (the "*Volk* duty") divorces dangerousness from the duty. The effect re-casts the objective criteria as a descriptor of a person's state of mind rather than what it actually is—a legal construct designed to install a minimum level of due process into state interference in the lives of the mentally ill. The decision is legally unsupportable, practically unworkable for therapists,[13] and worst of all, contradicts the legalist approach adopted in response to a repugnant policy of presuming the presence of a threat based simply on the existence of mental illness

7. *See* Petersen v. State, 100 Wash. 2d 421, 427, 671 P.2d 230, 237 (1983).

8. *See* Hafemeister et al., *infra* note 59, at 78; Slowbogin et al., *infra* note 67; Soulier et al. *infra* note 80, at 458.

9. 187 Wash. 2d 241, 386 P.3d 254 (2016).

10. *Id.* at 250, 386 P.3d at 260.

11. *Id.* at 250–51, 386 P.3d at 260.

12. *Id.* at 256, 386 P.3d at 263.

13. Referring to the broad swath of mental health professionals included under the umbrella term "mental health professionals," including psychiatrists, psychologists, psychiatric advanced registered nurse practitioners, psychiatric nurses, social workers and such other professionals as may be subject to state mental health laws. *See, e.g.*, WASH. REV. CODE § 70.05.020(30) (2016).

and nothing more.

First, contrary to precedent and related statutes, the *Volk* duty denies the necessity of: (1) a threat; (2) to a discernible victim; (3) by a patient who is under a degree of control by the therapist, either by context (i.e., hospitalization) or circumstance (warranting hospitalization). Put another way, it requires a therapist to take steps to protect the public from their patient regardless of whether he[14] presents an identifiable danger to others.[15] The concept of foreseeability is reduced to a mere forecast and the effect directly contradicts state and federal privacy laws.

Second, the *Volk* duty is unworkable on numerous fronts: it bifurcates a therapist's obligations depending on whether the patient is obtaining treatment in the inpatient or outpatient context, with less protection against third party liability in the latter context despite less control over the patient; it pits therapists' interests against their patients' interests, undermining the therapeutic relationship; and ultimately it places therapists in a catch-22: face third party liability for prioritizing a patient's rights and interests at the expense of taking steps to protect a potential (unknown) third party or, face malpractice liability for prioritizing the rights of a potential (unknown) third party by violating privacy laws and/or seeking unlawful confinement.

Finally, and I argue most troublingly, the *Volk* duty wholly undermines the legalist, rights-based model embraced to uphold the dignity and autonomy of the mentally ill. It shifts the locus of action away from objective-based criteria—the dangerousness standard—back toward a professional, discretion-oriented model of decision-making. This yank of the pendulum is justified as necessary to protect society. However, that justification ignores the fact that the contest between discretion and legalism already happened and resulted in the development and institution of the requirements now set to be ignored, and it does so at the expense of those who are mentally ill and *not* dangerous.

This Article proceeds in three parts. First, it traces the rise of rights-based mental health laws and the recognition of due process for the mentally ill, emphasizing the role that dangerousness played in cementing the new order. *Tarasoff* and the origin of the duty to protect is then discussed. Second, it identifies trends in the case law and legislative history surrounding the duty to protect to identify the implicit role that

14. Rather than using the phrase "he or she," this Article alternates between using the pronoun "he" or "she" for the sake of brevity.

15. *Volk*, 187 Wash. 2d at 266, 386 P.3d at 268.

dangerousness played in limiting the original broad reach of *Tarasoff*. In light of those trends, this Article reflects on how dangerousness, although flawed, represents the best option for mediating the tension between honoring the rights of individuals and protecting society. Finally, this Article sets out the facts and rulings of *Volk*, detailing the analysis briefly set out above. It concludes by calling for legislative reform. Absent a course correction, *Volk* invites a return to the false notion that the mentally ill are inherently dangerous. The patients' rights movement will be undermined, and we will be doomed to repeat the mistake of conflating the presence of mental illness with threats to society once again.

I. THE BIRTH OF RIGHTS-BASED MENTAL HEALTH LAWS, THE DANGEROUSNESS STANDARD, AND THE DUTY TO PROTECT

A. The Rise of Rights-Based Mental Health Laws and the Development of the Dangerousness Standard

Historically, society treated mental illness as a "defect," and afflicted individuals were considered "menaces," "deviant[s]," and persons from whom society needed protection.[16] In the first half of the twentieth century, few procedural protections stood between them and involuntary hospitalization or "civil commitment."[17] As such, commitment was indeterminate, based on vague but broad statutory language (e.g., "social menace"), and it captured many who posed no threat to society other than being different.[18] The basis for state intervention was two-fold: the state's police power and its *parens patriae* jurisdiction.[19] The latter created the state's obligation to care for those who could not care for themselves; the former required the state to protect the interests of its citizens. Broad authority under the police power was established early on when the United States Supreme Court ruled that it was a "fundamental principle that 'persons . . . are subject to all kinds of restraints and burdens, in order to secure the general comfort, health and

16. Buck v. Bell, 274 U.S. 200, 205–06 (1927); *see also* BRUCE A. ARRIGO, PUNISHING THE MENTALLY ILL: A CRITICAL ANALYSIS OF LAW AND PSYCHIATRY 6 (2002); John V. Jacobi, *Mental Health and Other Behavioral Health Services*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW, 7 (I. Glenn Cohen et al., eds., 2016).

17. ARRIGO, *supra* note 16, at 6.

18. *See generally* ARRIGO, *supra* note 16.

19. Gordon, *supra* note 2, at 6.

prosperity of the State.'"[20] Though established in the public health immunization context, the principle that individuals' rights were subordinate to the interests of society was quickly applied to justify the curtailment of mentally ill persons' liberty rights.[21]

Indeed, states drafted civil commitment statutes as a means of protecting others as much as the ill themselves.[22] Hospitalization was viewed as a necessary act of paternalism: all that was initially required was the existence of a mental illness or "disorder," which was vaguely defined,[23] and a physician's recommendation that treatment at a psychiatric hospital was "necessary."[24] The laws effectively institutionalized trust in professional opinion, which was characterized as "clinical judgment" in the case of psychiatry but, as noted by Larry Gostin, boiled down to a heavy dose of "personal intuition and subjective judgment."[25] These early laws were silent on the topic of rights; the concept of what was "just" for persons with mental illness was limited to the provision of care—care as the state saw fit.[26] Further, the consequences of the presence of a mental illness (e.g., whether an actual threat existed to the person or to others) were immaterial. Unsurprisingly, this period of mental healthcare has been critiqued as an exercise in social control,[27] laden with abuse of psychiatry's codified power.[28]

Beginning in the 1960s, there was an explosion of development in mental health law which shifted the legal framework governing the mentally ill away from enshrining the professional discretion of those empowered by the law towards instituting procedural protections for those subject to it.[29] Among the developments attributed to this shift was

---

20. Jacobsen v. Massachusetts, 197 U.S. 11, 25–26 (1905) (quoting Hannibal & St. J.R. Co. v. Husen, 95 U.S. 465, 471 (1877)).

21. *See* Buck v. Bell, 274 US 200, 205–07 (1927) (where the Court, relying on *Jacobson*, affirmed a judgment ordering a mentally "disabled" woman to be sterilized pursuant to a Virginia law that permitted the procedure in "mental defectives" on the basis, among others, that it would promote the welfare of society).

22. *See Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1222–23 (1974) [hereinafter *Developments in the Law*]; PERLIN & CUCOLO, *supra* note 4, § 3-1; Gordon, *supra* note 2, at 664.

23. *Developments in the Law*, *supra* note 22, at 1222.

24. *See* Gordon, *supra* note 2, at 665.

25. Gostin, *supra* note 1, at 56.

26. Jaclyn Greenberg, *A Right of Appeal Under Ontario's Health Care Consent Act: A Paper Victory is No Victory at All*, 44 OTTAWA L. REV. 433, 440 (2013).

27. *See e.g.*, ARRIGO, *supra* note 16, at 75–76.

28. Gostin, *supra* note 1, at 55–56.

29. *See* PERLIN & CUCOLO, *supra* note 4, at 6–10; Gostin, *supra* note 1, at 47–48.

the National Institute of Mental Health's creation of a model civil commitment statute, the Draft Act Governing Hospitalization of the Mentally Ill ("Draft Act").[30] It set out two grounds for involuntarily hospitalizing someone, namely, the "likelihood that the individual will injure himself or [injure] others if he is not confined."[31] The Draft Act caught fire quickly: as of 1961, only five of the thirty-seven states that had procedures in place for involuntary hospitalization contained a legal test requiring that the mentally ill person be "dangerous;"[32] by 1971, that number increased to nine;[33] by 1974, of the forty-five jurisdictions that had emergency involuntary commitment provisions, thirty-eight required that the individual appear "dangerous to themselves or others."[34] The dramatic uptick in revisions to commitment statutes reflected a "trend towards restricting involuntary civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness."[35] Further, the laws installed in a previously unchecked system a minimum level of scrutiny, subjecting the commitment process to judicial oversight from the outset.[36]

A series of landmark cases in the 1970s recognizing mentally ill persons' due process rights cemented this new legalism-oriented landscape. It began with *Lessard v. Schmidt*,[37] a 1972 federal district court decision which held that Wisconsin's civil commitment statute was constitutional only if it was construed to require that there was "an extreme likelihood that if the person is not confined he will do immediate harm to himself or others."[38] Further, proof of dangerousness must include a "finding of a recent overt act, attempt, or threat to do substantial harm to oneself or another."[39] That same year, the United States Supreme Court ruled in *Jackson v. Indiana*[40] that it was a

30. National Institute of Mental Health, *A Draft Act Governing Hospitalization of the Mentally Ill* (Public Health Service Pub. No. 51. 1952).

31. *Id.* at 28 (commentary).

32. PERLIN & CUCOLO, *supra* note 4, § 3-5.

33. *Developments in the Law*, *supra* note 22, at 1205.

34. *Id.* at 1204.

35. *Id.* at 1205.

36. National Institute of Mental Health, *supra* note 30, at vii (Foreword).

37. 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated and remanded for a more specific order*, 414 U.S. 473, *order on remand*, 379 F. Supp. 1376 (1974), *vacated and remanded on other grounds*, 421 U.S. 957 (1975), *order reinstated on remand*, 413 F. Supp. 1318 (1976).

38. *Id.* at 1093.

39. *Id.*

40. 406 U.S. 715 (1972).

violation of due process to involuntarily commit a criminally-accused person for an indefinite period solely on the basis of his incompetence to stand trial. The Court reasoned that the statute authorizing detention where it was in the interests of the welfare of "the person or . . . others" required a finding of dangerousness.[41] The Court held that there must be a reasonable relationship between the purpose of civil commitment and the nature and duration of commitment.[42] In so doing, Justice Blackmun observed: "[c]onsidering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this [police] power have not been more frequently litigated."[43]

Three years later, the Court affirmed the necessity of a finding of dangerousness in the seminal case, *O'Connor v. Donaldson*.[44] Kenneth Donaldson was committed to a Florida state hospital, on petition from his father, and told he would be there for a few weeks but ended up committed for nearly fifteen years.[45] He repeatedly challenged his commitment, each time denied with little explanation.[46] Donaldson alleged that his therapists intentionally and maliciously deprived him of his constitutional right to liberty, on the grounds that they had the ability to release him if he was not a danger to himself or others—which he was not—but refused to exercise their discretion.[47] The central issue on appeal dealt with the therapists' good faith intentions for continuing Donaldson's commitment absent a finding of dangerousness, which gave the Court cause to consider the constitutional authority for confinement of a non-dangerous person.[48] The Court unanimously decided that a state could not constitutionally confine someone who was "nondangerous" and capable of living safely in the community "without more."[49]

---

41. *Id.* Another lesser-known case from the same year, *Humphrey v. Cady*, 405 U.S. 504 (1972), added weight to the message. In that case, the Court interpreted a Wisconsin statute governing sex crimes as violating the equal protection clause because persons committed under that act were not permitted a jury determination whereas those committed under a mental health statute were. The Court held that the statute required a "social and legal judgment that [the mentally ill person's] potential for doing harm . . . to others [is] great enough to justify such a massive curtailment of liberty." *Humphrey*, 405 U.S. at 509.

42. *Jackson*, 406 U.S. at 738.

43. *Id.* at 737.

44. O'Connor v. Donaldson, 422 U.S. 563 (1975).

45. *Id.* at 564.

46. *Id.* at 565.

47. *Id.* at 567–68.

48. *Id.* at 570–78.

49. *Id.* at 576. For a more recent example, see *Boller v. State*, 775 So. 2d 408, 409–10 (Fla. Dist. Ct. App. 2000) (ruling that it was unconstitutional to commit a woman who refused to take her psychotropic medication, in spite of her mental deterioration).

B. Tarasoff v. Regents of the University of California *and the Development of the Duty to Protect*

Around the time that the Court was strengthening the legal protections of the mentally ill in *O'Connor*, victims of violence by mentally ill persons won legal protection in the famous California Supreme Court case, *Tarasoff v. Regents of University of California*.[50] The decision sent shockwaves through the mental healthcare community when it departed from the general rule that no person has a duty to protect a third party from harming another,[51] to rule that psychotherapists, including psychiatrists, have a duty to protect "foreseeable victims" of their patients' violent actions.[52]

The *Tarasoff* facts are well known: a college student murdered a woman he was obsessed with after he told his therapist he intended to do so.[53] The student never identified the woman but the therapist could have learned her identity.[54] In any event, the therapist reported the student to campus police and urged them to have the student committed.[55] After interviewing the student and obtaining his promise to stay away from the woman, the police declined to do so.[56] The therapist's supervisor demanded that the police return the therapist's letter urging commitment, and told the therapist to destroy his notes and take no further action.[57] No one warned the woman or her parents, and two months later, the student murdered her.[58] The parents sued the therapists, among others, alleging that they were negligent in failing to (1) detain a dangerous patient; (2) warn the victim or those who could inform her; and (3) generally protect the victim from the student's "dangerous propensities."[59]

The California Supreme Court ruled on the case twice—a fact that continues to muddy the literature and jurisprudence on the precise nature and content of the duty.[60] Many consider *Tarasoff* to have established a

50. 551 P.2d 334 (Cal. 1976).

51. *Id.* at 385.

52. *Id.* at 334.

53. *Id.* at 339.

54. *Id.* at 432.

55. *Id.*

56. *Id.*

57. *Id.* at 341.

58. *Id.* at 339–40.

59. *Id.* at 341–42.

60. *See* Thomas L. Hafemeister et al., *Parity at a Price: The Emerging Professional Liability of Health Providers*, 50 SAN DIEGO L. REV. 29, 76–77 (2013); Derek Truscott, *The Psychotherapist's*

"duty to warn," when in fact it created a broader "duty to protect." The first decision, released in 1974, did establish that therapists had a *duty to warn* their patients' foreseeable victims.[61] That ruling provoked a swift, organized response from the mental health community culminating in the submission of an amicus curiae brief to the Court setting out their concerns, namely that the ruling would require therapists to breach patients' privacy rights (potentially destroying the therapeutic alliance), and highlighting the limitations on therapists' ability to predict dangerousness (thus holding these professionals to an impossible standard).[62] The Court agreed to review the case but the result arguably created a much broader scope of liability.

In its second decision, released in 1976, the California Supreme Court created a *duty to protect*, holding:

> 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 on 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, to notify the police, or to take whatever other steps are reasonably necessarily under the circumstances.[63]

The *duty to protect* requires whatever steps are necessary under the circumstances, which could simply include warning the intended victim, but likely more when no victim is identified.[64] Some have argued that the first case left such a lasting (and alarming) impression that the true precedent never sunk in.[65] It is equally plausible that the prevalence of the "duty to warn" can be attributed to the fact that the defendant therapists had immunity from their failure to commit the student,[66] leaving only their failure to warn as a potential valve of liability. Further, subsequent California decisions limited the scope of the duty (to protect)

Duty to Protect: An Annotated Bibliography, 21 J. PSYCHIATRY & L. 221, 222 (1993).

61. *Tarasoff*, 529 P.2d at 553.

62. James C. Beck, *The Therapist's Legal Duty When the Patient May Be Violent*, 11 PSYCHIATRIC CLINICS OF N. AM. 665, 667 (1988).

63. *Tarasoff*, 551 P.2d at 340.

64. *Id.*

65. *See* Beck, *supra* note 62, at 668; Hafemeister et al., *supra* note 60, at 77–78.

66. *Tarasoff*, 551 P.2d at 351 (referencing CAL. GOV'T. CODE § 856 (West 2017)).

to readily identifiable victims.[67]

The basis for establishing the duty to protect chiefly rested on the "special relationship" between the therapist and the patient, as well as the foreseeability of the victim. Notwithstanding the imprecise nature of the concept of foreseeability,[68] the *Tarasoff* majority declared that it was the most important consideration in establishing the existence of a duty.[69] It relied on section 315 of the Restatement (Second) of Torts to support its ruling, holding:

> When the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person. . . . Since the relationship between a therapist and his patient satisfies this requirement, we need not here decide whether foreseeability alone is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct.[70]

Section 315 is an exception to the general rule that no one owes a duty to protect a third party from harming another.[71] It states:

> A person has a duty to control the conduct of a third person and thereby to prevent physical harm to another if:
>
> (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
>
> (b) a special relation exists between the actor and the other which gives to the other a right to protection.[72]

Section 315 has been interpreted as requiring a relationship to be "definite, established and continuing," and as containing some degree of

---

67. *See, e.g.*, Thompson v. Cty. of Alameda, 614 P.2d 728 (Cal. 1980) (in which the California Supreme Court narrowed *Tarasoff* in ruling that therapists' duty to third parties is contingent on their patients threatening an identifiable victim; and that, therapists did not have a duty to warn a victim of a patient with a history of violence who had made nonspecific threats and was due to be released from confinement); Mavroudis v. Superior Court, 102 Cal. Rptr. 724, 729 (Cal. Ct. App. 1980).

68. CHRISTOPHER SLOWBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 210 (6th ed., 2014) (the foreseeability criteria, although a widely-accepted benchmark in determining liability is a "decidedly imprecise standard that nevertheless extends professional liability beyond the limits set by the privity doctrine").

69. *Tarasoff*, 551 P.2d at 342.

70. *Id.* at 342–43.

71. *Id.* at 345.

72. RESTATEMENT (SECOND) OF TORTS § 315 (AM. LAW INST. 1965).

control by the defendant over a third party.[73]

The California Supreme Court observed that the exception arises where the defendant "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."[74] It provided two examples of where this special relationship would give rise to affirmative duties for the benefit of third parties: a hospital that controls a patient who may endanger others would be required to take reasonable measures to control the behavior of that patient (e.g., it would be negligent of a mental hospital to permit the escape or release of a dangerous patient), and a doctor who prescribes medication to a patient that renders the patient a danger to others would need to warn the patient of the effects of the medication (e.g., it would be negligent for a doctor to prescribe drugs that cause drowsiness to a bus driver without bringing the effect of the drug to the patient's attention).[75]

According to the majority: "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."[76]

Dangerousness appears to be a requisite component of the duty to protect. That is, the decision appears to create a two-pronged duty: first, determine that a patient poses a serious danger of violence to others; then, assuming that determination is positive, exercise reasonable care to protect the foreseeable victim(s) of that danger.

Such an interpretation would have been easily married to the broader developments demanding objective criteria for involuntary commitment: if a patient is deemed dangerous, there exists a threat warranting the therapist to take protective action, either to initiate commitment proceedings or warn the victim, the authorities, or both. If the decision is made *not* to commit someone (e.g., because the patient is not exhibiting signs of a mental illness), a call to action nevertheless remains, likely in the form of a warning. If commitment is inappropriate *and* there is no one identifiable to warn, then the patient is not dangerous, as defined, and foreseeability is not present. That is, the basis for exercising the

---

73. Binschus v. State, 186 Wash. 2d 573, 579, 380 P.3d 468, 471 (2016) (quoting Taggart v. State, 118 Wash. 2d 195, 219, 822 P.2d 243, 255 (1992)).

74. *Tarasoff*, 551 P.2d at 343 (referring to the cluster of provisions in the Restatement (Second) of Torts dealing with the requirement to exercise control, §§ 315–320).

75. *Id.* at 343–44.

76. *Id.* at 345.

police power—to protect public safety, which was the policy reason driving *Tarasoff*[77]—is inchoate. As applied to the therapists in *Tarasoff*, there was clearly a determination that the patient was dangerous but they failed to take appropriate action; a failed effort to have him committed fell short of the danger they foresaw.

Unfortunately, the above analysis was not how the law was construed. Arguably, it is more consistent with the dissenting opinion of Justice Mosk, which would have limited the duty to warn to those cases in which the therapist does in fact predict violence.[78] For Justice Mosk, liability would only arise if the therapist concluded that her patient was likely to be violent and took no steps to neutralize the threat of harm.[79]

The reality was that the mental healthcare and legal communities responded to the expectation that therapists take steps to protect third parties *in any event* (i.e., regardless of whether the patient was a danger to others). Dangerousness was an afterthought, conflated with the concept of foreseeability. Nevertheless, as will be shown in the next section, dangerousness remained a crucial ingredient in analyzing whether the duty to protect exists in a given circumstance.

II. TRENDS IN THE DUTY TO PROTECT CASE LAW AND REFLECTIONS ON THE ROLE OF DANGEROUSNESS WITHIN IT

A. Trend Spotting Among Tarasoff's *Progeny*

Forty years after *Tarasoff*, it is axiomatic to point out that the decision spawned a cottage industry of criticism and commentary. The mental healthcare community struggled to make sense of the decision and clinicians and lawyers pounced on the ruling's many shortcomings. Among them were that the decision (1) falsely assumed professionals could predict a patient's propensity for violence; (2) compromised patient confidentiality, undermining the therapeutic relationship; (3) invited increased violence, as those most in need of treatment would withdraw for fear of premature persecution; (4) spurred involuntary commitment proceedings, unlawfully hampering the mentally ill's liberty interests; (5) chilled professionals from accepting the most in need, and potentially violent, clients; and (6) created confusion as to

77. *Id.* at 346.

78. *Id.* at 354.

79. *Id.*

what standard applied.[80] Reflecting on the decision decades later in 1992, Michael L. Perlin observed: "Its very existence has reshaped the configurations of mental health practice, and has altered the relationship between clinicians and public authorities."[81] In particular, it was reported that clinicians found the duty to protect jurisprudence "perplexing [for] its inconsistency and unpredictability."[82] Some cases were perceived "to make little or no clinical sense," particularly those interpreting *Tarasoff* to create even broader obligations to a larger class of third parties than initially construed.[83]

And yet, subsequent literature surveys of case law reveal a certain degree of consistency for finding as a matter of law that a duty to protect existed (or not). In their 1992 review for the *Defense Counsel Journal*,[84] Douglas M. McIntosh and Carmen Y. Cartaya reviewed two types of cases evolving from *Tarasoff*: claims predicated on allegations of a failure to warn and claims predicated on allegations of a failure to detain. Both claims comprised the same three basic elements: (1) the existence of a special relationship between therapist and patient, (2) a context in which the therapist controlled the patient to some degree (i.e., hospitalization), and (3) the therapist's ability to predict dangerousness based on voiced threats to identifiable victims (i.e., foreseeability).[85] Their review revealed that liability narrowed considerably to the inpatient context, as the outpatient context exhibited "[a lack of] sufficient elements of control."[86] In other words, the authors recognized a spectrum of control: inpatients "surrendered" control to their providers

---

80. *See* Hafemeister et al., *supra* note 60, at 76–78; Matthew F. Soulier et al., *Status of the Psychiatric Duty to Protect, Circa 2006*, 38 J. AM. ACAD. PSYCH. L. 457, 457 (2010) (citing references omitted).

81. Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOL. REV. 29, 62 (1992).

82. Hafemeister et al., *supra* note 60, at 76.

83. Soulier et al., *supra* note 80, at 457 (discussing Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980); Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983)).

84. Douglas M. McIntosh & Carmen Y. Cartaya, *Psychotherapist as Clairvoyant: Failing to Predict and Warn*, DEFENSE COUNSEL JOURNAL 569, 569 (Oct. 1992).

85. *Id.* at 570–71.

86. *Id.* (citing Sellers v. United States, 870 F.2d 1098 (6th Cir. 1989); Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982); Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1980), *aff'd*, 676 F.2d 686 (3rd Cir. 1982); Cooke v. Berlin, 735 P.2d 830 (Ariz. 1987); Bauer v. S.W. Denver Mental Health Ctr. Inc., 701 P.2d 114 (Colo. App. 1985); Garrison Retirement Home Corp. v. Hancock, 484 So. 2d 1257 (Fla. Dist. Ct. App. 1985); Bradley Ctr. Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982); Estate of Mathes v. Ireland, 419 N.E.2d 782 (Ind. Ct. App. 1981); Littleton v. Good Samaritan Hosp. & Health Ctr., 529 N.E.2d. 449 (Ohio 1988); Yellen v. Phila. State Hosp., 503 A.2d 1108 (Pa. Comw. Ct. 1986).

whereas outpatients did not. Providers in the outpatient context have "no right or ability . . . to control the conduct of the patient," which the authors implied was insufficient, stating: "if control arguably is not present, the defense should prevail."[87]

As to foreseeability, the concept arose where there was a specific threat to an identifiable victim—which, it bears emphasizing, mirrors the dangerousness criteria for involuntary commitment. The authors referred to *Brady v. Hopper*,[88] the famous case arising from an attempted assassination of then-president Ronald Reagan.[89] In that case, the Tenth Circuit Court of Appeals affirmed a Colorado district court ruling that the "specific threats to specific victims rule states a workable, reasonable and fair boundary upon the sphere of a therapist's liability to third persons for the acts of their patients;"[90] it added that "[u]nless a patient makes specific threats, the possibility that he may inflict injury to another is vague, speculative and a matter of conjecture."[91] In other words, the authors summarized, foreseeability only arises once there are direct threats to identifiable victims; prior to that, foreseeability is inchoate.[92]

In his 1987 review, James C. Beck similarly reported that the triggers of recognizing the duty are the degree of control vis-à-vis the assailant's inpatient/outpatient status and the foreseeability of violence.[93] Beck's foreseeability analysis was based on three factors, the presence or absence of which determined the degree of foreseeability: the patient's history of violence, a threat to a specific person, and the existence of apparent motive. Where two out of the three conditions were present, the danger was "clearly foreseeable;" where one was present, the danger

---

87. *Id.* (citing Farwell v. Un, 902 F.2d 282 (4th Cir. 1990); Currie v. United States, 836 F.2d 209 (4th Cir. 1987); Abernathy v. United States, 773 F.2d 184 (8th Cir. 1985); King v. Smith, 539 So. 2d 912 (Ala. 1989); Fisher v. Metcalf, 543 So. 2d 785 (Fla. Dist. Ct. App. 1989); Paddock v. Chacko, 522 So. 2d 410 (Fla. Dist. Ct. App. 1988), *review denied*, 553 So. 2d 168 (Fla. 1989); Wagshall v. Waghsall, 538 N.Y.S.2d 597 (N.Y. App. Div. 1989)).

88. 570 F. Supp. 1333 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984).

89. *Id.*

90. *Id.*

91. *Id.* at 1338.

92. McIntosh & Cartaya, *supra* note 84, at 571 (citing *Sellers*, 870 F.2d 1098; *Cooke*, 735 P.2d 830; Vu v. Singer Co, 706 F.2d 1027 (9th Cir. 1983), *cert. denied*, 464 U.S. 938 (1985); Cantrell v. United States, 735 F. Supp. 670 (E.D. N.C. 1988); *Brady*, 570 F. Supp. 1333; Morton v. Prescott, 564 So. 2d 912 (Ala. 1990); Thompson v. Cty. of Alameda, 614 P.2d 728 (Cal. 1980); Eckhardt v. Kirts, 534 N.E.2d 1339 (Ill. Ct. App. 1989); Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983); Bardoni v. Kim, 390 N.W. 2d 218 (Mich. Ct. App. 1986); Sherrill v. Wilson, 653 S.W.2d 61 (Mo. 1983).

93. James C. Beck, *The Psychotherapist's Duty to Protect Third Parties from Harm*, 11 MENTAL & PHYSICAL L. REP. 141, 141 (1987).

was "questionably foreseeable," and where none were present, the violence was "unforeseeable."[94] Of the eleven cases that fell under the "clearly foreseeable" category, ten courts found that the therapist(s) owed the victim(s) a duty to protect.[95] Six of the ten cases involved outpatients. Of those, only two ultimately led to liability: *Jablonski v. United States*[96] and *Davis v. Lhim*.[97]

In *Jablonski*, Veterans Administration ("VA") psychiatrists were liable for the death of a woman who was killed by a VA outpatient. Jablonski never threatened his girlfriend (the victim) but he had attempted to rape her mother a few weeks prior to the index offense.[98] The mother had contacted the police, who in turn contacted a VA psychiatrist about the incident and the outpatient's potential dangerousness but the psychiatrist never passed along the message.[99] When Jablonski and his girlfriend arrived at the VA, he informed the intake psychiatrist that he had spent five years in jail for raping his wife.[100] The psychiatrist suggested hospitalization but Jablonski refused. He did, however, accept outpatient treatment.[101] Parenthetically, involuntary commitment was rejected on the basis that Jablonski was not suffering from a mental disorder, so defined.[102] The psychiatrist did advise Jablonski's girlfriend, who confessed to being afraid of Jablonski, to leave him but she refused.[103] Two other psychiatrists assessed him and found that he was dangerous but not committable, and made further outpatient treatment arrangements, and a third psychiatrist told the girlfriend to stay away from him.[104] She ignored the advice and returned to the apartment they had shared, where he murdered her.[105] At trial, the therapists were found to be negligent in failing to transmit the message from the police, failing to secure Jablonski's past medical records, and

94. *Id.*

95. In the eleventh case, the court concluded that there was a duty to commit. *See* Currie v. United States, 836, F.2d 209 (4th Cir. 1987).

96. 712 F.2d 391 (9th Cir. 1983).

97. 335 N.W.2d 481 (Mich. Ct. App. 1983), *aff'd*, 382 N.W.2d 195 (Mich. Ct. App. 1985), *rev'd* Canon v. Thumudo, 422 N.W.2d 688 (1988) (overturned on statutory immunity grounds in respect of the improper discharge and failure to warn allegations).

98. *Jablonski*, 712 F.2d at 393.

99. *Id.*

100. *Id.* at 392.

101. *Id.* at 393.

102. *Id.*

103. *Id.*

104. *Id.* at 394.

105. *Id.*

failing to warn the patient.[106]

In *Davis*, a former inpatient shot and killed his mother two months after he was released from the state hospital.[107] He had been suffering from chronic paranoid schizophrenia but had no history of violence; the only evidence of a threat was in a two-year old emergency room note suggesting the patient was threatening his mother for money.[108] The victim's estate alleged that the patient was negligently discharged and that the victim was not warned that her son was a danger to her safety.[109] The Michigan Court of Appeals upheld the trial court ruling against the hospital psychiatrist, finding, *inter alia*, that the defendant owed a duty of reasonable care to a third party who is foreseeably endangered by his patient, that the duty only extended to readily identifiable victims rather than the public at large, and that there was evidence to support a finding that the defendant should have known that the patient was a danger to the deceased.[110] That decision, however, was subsequently overturned by the state supreme court on statutory immunity grounds.[111]

Beck described *Jablonski* as unreasonable,[112] and a 2010 *Tarasoff* case law review by Soulier and colleagues, among others,[113] named both *Jablonski* and *Davis* as among the cases that were so problematic as to trigger legislative response.[114] The criticisms of the two cases were obvious: in *Jablonski*, whatever delinquencies may have existed in the therapists' management and care, it is hard to see how their conduct ultimately caused the victim's death. After all, they made multiple warnings. In *Davis*, the issue was the (lack of) imminence of the threat. Even accepting, as Beck did, that there was some history of threats of violence, that history was years old and the patient was released months before the crime took place. Foreseeability may be broad, but *Davis* suggested a threshold bordering on indeterminate.

Beck and Soulier and colleagues (among others)[115] characterized two other cases as troubling outliers, which are an indefensible stretch from

106. *Id.* at 398.

107. Canon v. Thumudo, 422 N.W.2d 688, 696–67 (Mich. 1989).

108. *Id.*

109. *Id.* at 699.

110. Davis v. Lhim, 382 N.W.2d 195, 198–99 (Mich. Ct. App. 1983), *aff'g*, 335 N.W.2d 481 (1983).

111. *Canon*, 422 N.W.2d at 700–01.

112. Beck, *supra* note 93, at 142; Beck, *supra* note 62, at 671.

113. *See, e.g.*, Hafemeister et al., *supra* note 60, at 78.

114. Soulier et al., *supra* note 80, at 458.

115. *See, e.g.*, Hafemeister et al., *supra* note 60, at 76–78.

Tarasoff: *Lipari v. Sears*[116] and *Petersen v. State*.[117] In these cases, the only two which Beck classified as "unforeseeable" and which imposed liability, the courts found that the danger "was so foreseeable that the duty runs to society at large."[118] These cases involved strangers who were harmed either by unprovoked attack or motor vehicle accidents. In *Lipari*, in response to a random shooting in a night club by an outpatient, a Nebraska district court found that a psychiatrist had:

> [A]n affirmative duty for the benefit of third persons. . . . [requiring a] therapist [to] initiate whatever precautions are reasonably necessary to protect potential victims of [the] patient. . . . when, in accordance with the standards of his profession, the therapist knows or should know that [the] patient's dangerous propensities present an unreasonable risk of harm to others.[119]

The *Lipari* court's reasoning was in large part based on the special relationship under section 315 of the Restatement (Second) of Torts.[120] As to foreseeability, the court suggested that *Tarasoff* did not require the identifiability of the victim but acknowledged that its progeny limited the scope of the duty to identifiable victims.[121] Nevertheless, it preferred another line of cases (unrelated to the psychiatric context)[122] that professionals owed a duty to any foreseeably endangered person of the general public[123]—an expansive, if not the most expansive, interpretation of the duty.[124]

In *Petersen*, Cynthia Petersen sued Washington State for injuries she sustained after a recently released inpatient from a state mental health hospital ran a red light and crashed into her car.[125] Larry Knox was

116. 497 F. Supp. 185 (D. Neb. 1980).

117. 100 Wash. 2d 421, 671 P.2d 230 (1983).

118. Beck, *supra* note 93, at 145.

119. *Lipari*, 497 F. Supp. at 193.

120. *Id.* at 189.

121. *Id.* at 194.

122. *See e.g.*, Kaiser v. Suburban Transp. Sys., 65 Wash. 2d 461, 398 P.2d 14, 18–19 (1965) (finding a physician liable to a third party for prescribing medication to a bus driver without warning the driver that the drugs could make him drowsy; the third party was a passenger on a bus driven by the patient that was involved in an accident). As Freedman points out, "the duty to the plaintiff was a duty that undeniably existed in the first place" given his knowledge of the patient's occupation and his medication condition. *See* Freedman, *supra* note 5, at 272–74.

123. *Lipari*, 497 F. Supp. at 194.

124. *See* James L. Knoll IV, *The Duty to Protect: When Has It Been Discharged?*, PSYCHIATRIC TIMES (July 2, 2012), http://www.psychiatrictimes.com/challenging-cases/duty-protect-when-has-it-been-discharged/page/0/2 [https://perma.cc/7RXH-76FC].

125. Petersen v. State, 100 Wash. 2d 421, 422–23, 671 P.2d 230, 234–35 (1983).

committed one month earlier, after he castrated himself while high on angel dust.[126] He was on parole at the time, conditioned on him not using illicit drugs. In the hospital, he was diagnosed with a schizophrenia-like reaction to drugs, and his period of committal was extended.[127] Just prior to discharge, Knox was apprehended by hospital security for driving recklessly in the parking lot. Nevertheless, he was released the next day.[128] Five days later, he crashed into Petersen.[129] She alleged that the state failed to protect her from Knox's "dangerous propensities," and that the treating therapist should have sought additional confinement or disclosed his parole violation.[130] At trial, the jury agreed, and ruled that the therapist was grossly negligent.[131] The Washington State Supreme Court affirmed, relying on *Lipari*, and reasoned that the doctor knew her patient was "potentially dangerous," and "would be unpredictable," likely to experience hallucinations if he used illicit drugs, likely to use illicit drugs again, and yet failed to take any action.[132]

The reviews by McIntosh and Cartaya, Beck, and Soulier and colleagues delivered variations on the same theme: fears of the effects of *Tarasoff* were for naught. *Tarasoff*, *Lipari*, and *Petersen* and their ilk, although worrisome, were true outliers, and most other cases provide reasonable assurances of the limits of the duty to protect. As Beck points out, the mere imposition of the duty to protect as a matter of law does not automatically result in a verdict that a therapist was negligent.[133] Beck's position is far from academic. The Washington, California, and Nebraska courts all emphasized that the provision of (reasonable) care under the circumstances, based on professional standards of practices, will limit the imposition of so broad a duty to protect. On the other hand, as Soulier and colleagues acknowledge, the available case law hardly represents the universe of litigation involving therapists and third party victims. Their study dealt only with state and federal appellate cases, not trial court cases which were not appealed or those that never proceeded to trial.[134]

But there is a more direct explanation for the curtailment of concerns

126. *Id.* at 423–24, 671 P.2d 235–36.

127. *Id.*

128. *Id.*

129. *Id.*

130. *Id.* at 424, 671 P.2d at 235.

131. *Id.*

132. *Id.* at 428, 671 P.2d at 236.

133. *See* Beck, *supra* note 62, at 668.

134. Soulier et al., *supra* note 80, at 467.

arising from *Tarasoff*: the precedential value of its progeny, particularly the more extreme cases, was short-lived. Therapists effectively lobbied state legislatures to enact laws to restrict those worrisome precedents and to provide clear guidance on the parameters of the duty to protect.[135] According to the Soulier review, thirty-seven states adopted legislation limiting the duty in one respect or another (e.g., requiring the identifiableness of the victim(s) or that the threat be "serious" and/or "imminent").[136] In particular, California's involuntary commitment statute, the Lanterman-Petris-Short Act, was modified in 1985 to effectively codify the cases narrowing *Tarasoff* to identifiable victims of a specific threat, by immunizing therapists from liability "[e]xcept if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims."[137] Nebraska similarly modified its involuntary commitment statute post-*Lipari*, to preclude a cause of action against mental health providers for failing to warn and protect third parties except "when the patient has communicated to the mental health practitioner a serious threat of physical violence against . . . reasonably identifiable victims or victims."[138]

Petersen, too, was narrowed by the Washington Legislature.[139] In 1987, the state's immunity statute, section 71.05.120 of the Revised Code of Washington, was amended to read as follows (in relevant part):

> (1) No officer of a public or private agency . . . attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter . . . shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.
>
> (2) *This section does not relieve a person from . . . the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The duty to warn or to take*

135. *Id.* at 458.

136. *Id.*

137. CAL. CIV. CODE § 43.92(a) (West 2016).

138. NEB. REV. STAT. § 38-2137 (West 2016).

139. For a thorough critique, see generally Freedman, *supra* note 5.

> *reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.*[140]

Section 71.05.120 of the Revised Code of Washington narrowed *Petersen*'s duty to protect any foreseeable victim to warning identifiable victims; all other circumstances in managing a person's institutionalization, apart from bad faith and gross negligence, were subject to that provision's immunity.[141] The broad duty that elicited such an outcry was effectively erased, state by state. Further, as Soulier and colleagues report, regardless of whether a state enacted a statute, courts "almost always found that defendants owed no duty to the public at large,"[142] unlike the rulings of *Petersen* and *Lipari*.

To the extent that there was some duty owed to society generally, it was better construed as a duty to commit. This was recognized by a Fourth Circuit Court case, *Currie v. United States*.[143] In that case, an IBM employee, who was a Vietnam veteran with post-traumatic stress disorder, shot and a killed a co-worker and injured others, despite efforts by a VA treatment team to diffuse the situation.[144] The treatment team was aware of the danger the man posed but they could not commit him since he was not suffering from a mental illness, so defined under North Carolina statute.[145] Nevertheless, they warned IBM, as well as local, state, and federal authorities.[146] The estate of the deceased alleged that the treatment team failed to commit the assailant, which gave the circuit court the opportunity to weigh the distinctions between the *Tarasoff* "duty to warn" and the (potential) duty to commit. The court stated:

> The duty to warn . . . runs only to identifiable persons within a recognizable zone of danger, and little resembles a general

---

140. *See* Act effective July 25, 1987, ch. 212, § 301, 1987 Wash. Sess. Laws 774, 775–76 (codified as amended at WASH. REV. CODE § 71.05.120 (2016)) (emphasis added). Note that subsection (2) is now subsection (3) after a 2016 amendment that is not relevant to this paper was inserted as the new subsection (2). It is referred to as subsection (2) in this paper, for clarity and consistency with *Volk*, 337 P.3d 372 (2014).

141. *See* Hahn v. Chelan-Douglas Behavioral Health Clinic, No. 27656–2–III, 2009 WL 3765993, at *3 (Wash. Ct. App. Nov. 12, 2009) (noting that WASH. REV. CODE § 71.05.120(2) "does not create a duty to warn; it tells health care providers who fail to live up to the duty to warn that they will not receive the benefit of the immunity statute").

142. Soulier et al., *supra* note 80, at 470.

143. Currie v. United States, 836 F.2d 209 (4th Cir. 1987).

144. *Id.* at 210–11.

145. *Id.* at 211–12.

146. *Id.* at 211.

> responsibility for a third person's conduct. A duty to commit, if there is such a duty, runs to all persons suffering foreseeable harm, whether or not those persons are subject to identification in advance.[147]

Accordingly, therapists do not owe society a duty absent a basis for seeking a person's commitment—that is, absent dangerousness.

In all, the trajectory of the duty to protect, through the courts and state legislatures, reveals a few meaningful trends. First, after a broad and potentially unworkable start in *Tarasoff*, the duty to protect was largely reformed to the duty to warn. Second, the duty applies to therapists who not only have a "special relationship" with their patients, but also have a degree of control over them; where they do not, the duty is even more circumscribed. Accordingly, the outpatient context goes one step too far, particularly where indicators of foreseeability (e.g., past history of violence, specific threat, and apparent motive) are absent. Third, the duty extends to identifiable victims who are the subject of specific threats, not the general public. Finally—and I would argue most notably—the imposition of the duty to protect never strayed far from the objective criteria under the dangerousness standard.

The circuit court's comment in *Currie*, above, is illustrative. Assume the duty to protect can be construed as an umbrella under which therapists may take certain action depending on the circumstances, including initiating commitment of some kind and warning those who may be harmed and/or could prevent the harm from occurring. (Parenthetically, it is unclear what other options exist besides variations of these two, though courts always suggest there are others.[148]) Either the patient makes a specific threat to an identifiable person, prompting at the very least, a duty to warn, or the patient presents a *general* danger to others such that danger is reasonably foreseeable, prompting a duty to commit. If neither scenario can be played out, this means the duty to protect should not be triggered—danger is not foreseeable.

B. Reflections on the Dangerousness Criteria: An Imperfect but Necessary Tool

Though I argue that dangerousness is implicitly required in recognizing a therapist's duty to protect others—or at the very least, that it ought to be—the reality is that *Tarasoff* and its progeny have been

147. *Id.* at 213.

148. *See, e.g.*, Petersen v. State, 100 Wash. 2d. 421, 427, 671 P.2d 230, 237 (1983); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 193 (D. Neb. 1980).

interpreted to require therapists to take steps to protect third parties *in any event*. It is conceivable that this was because California's involuntary commitment statute provided the defendant-therapists in *Tarasoff* immunity from decisions regarding whether to commit or release a person,[149] and thus, placed emphasis on the presence of dangerousness which could be construed as conflicting with that provision. But the Court drew no such link. Instead, the relationship between the duty to protect and dangerousness was left unclarified, emphasizing instead the traditional tort concept of foreseeability. This was despite the *Tarasoff* majority's clear emphasis on dangerousness in recognizing the duty to protect. Recall that the Court held: "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*."[150] This begs the question: why did the Court choose not to explicitly set out the relationship between the duty to protect a patient's potential victim(s) and the patient's dangerousness? Any answer is purely conjecture, but a reasoned guess is that explaining the role the criteria plays in justifying intervention generally was far from a simple, or uncontroversial task.

For starters, there is ongoing difficulty setting out precisely what dangerousness refers to. Definitions are legion, and defining the term has been called the most "vexing" issue.[151] One definition often referred to includes four components: (1) magnitude of harm; (2) probability that harm will occur; (3) frequency with which harm will occur; and (4) the imminence of harm.[152] But even with the benefit of that framing, questions abound. Does it include self-harm in addition to harming others? What will constitute a minimum level of harm? Must the harm be physical? What is the maximum length of time that qualifies as "imminent?" The list of unanswered questions is significant.

In addition, there is the issue of accurately predicting an act of violence. Early predictive efforts were criticized, resulting in the psychiatry community developing standardized tests—such as actuarial

149. Tarasoff v. Regents of the Univ. of Cal., 551 P.2d 334, 351 (Cal. 1976) (emphasis added) (relying on Cal. Gov't Code § 856 (West 2017), which affords public servants such as the therapists "absolute protection" from liability for "any injury resulting from determining in accordance with any applicable enactment . . . whether to confine a person for mental illness").

150. *Id.* at 345.

151. *See* PERLIN & CUCOLO, *supra* note 4, § 3-4.1 (referencing Harry Kozol, *Dangerousness in Society and Law*, 13 U. TOL. L. REV. 241, 241 (1982) ("Dangerousness, as an attribute of human nature, has been the bane of man's existence since time immemorial.")).

152. A.D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 680 (1974).

risk assessment instruments—to help clinicians evaluate the likelihood that an individual would become violent.[153] Over time these tools have become more sophisticated, but they are far from precise.[154] Debate continues over their accuracy, with experts in the field reporting that "virtually" all scholarship in the area agrees predictions are less accurate than chance.[155] They are also laden with the value judgments of the person employing them. The therapist's judgment is crucial to any evaluation, from whether to initiate use of the standardized risk assessment tools to the results they conjure. For these reasons, one can appreciate the difficult balance that must be struck in attempting to evaluate a mentally ill person's potential for violence, and to not unduly rely on the very thing the dangerousness standard was meant to replace: professional discretion. The fact of the matter is that the legal standard is driven by medical judgment, causing the observation that, "[p]sychiatrists . . . are asked to make both clinical and legal determinations."[156]

There are also ongoing debates about whether the criteria achieves the aims set out for it. Some argue that the dangerousness criteria can be too broad, permitting commitment without clear evidence that serious

153. Gordon, *supra* note 141, at 672.

154. *Id.* at 690; *see also* John Monahan, *Tarasoff at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 504–55 (2006) (writing on the merits of predictions insofar as they are based on the presence of certain attributions associated with a propensity for violence (e.g., sex, age, prior history of violence, unemployment, etc.)).

155. *See* PERLIN & CUCOLO, *supra*, note 4, § 3-4.2.1 (referencing the American Psychiatric Association's position to the United States Supreme Court in *Barefoot v. Estelle*, 463 U.S. 880, 918–20 (1983) that two thirds of predictions of long-term future violence by psychiatrists are wrong. In *Barefoot*, two psychiatrists were called to testify during the sentencing phase of a man convicted for killing a police officer. Their evidence was that the man was likely to commit further acts of violence and would remain a danger to society. The jury sentenced the man to death and he appealed on the grounds that (1) it was unconstitutional to permit psychiatrists to testify about future conduct since they cannot predict the future and (2) these psychiatrists' testimony was unconstitutional since they had never personally examined him. The majority disagreed on the basis that precedent authorized the testimony for the purposes of predicting dangerousness, which was relevant for sentencing. Further, expert testimony need not be based on personal examination to be admissible. Justice Brennan, dissenting, wrote that (unreliable) scientific evidence was likely to prejudice the jury, and must be held to a stricter evidentiary standard than permitted by the majority, specifically a stricter standard than the evidence was capable of meeting. Ten years later, in *Heller v. Doe*, 509 U.S. 312, 324 (1993), the Court seemed to implicitly reverse itself insofar as it acknowledged the frailty of psychiatric predictive evidence (noting that "many psychiatric predictions of future violent behavior by the mentally ill are inaccurate"); Donald H. Stone, *Confine is Fine: Have the Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study to Unravel the Psychiatrist's Crystal Ball*, 20 VA. J. SOC'L POL'Y & L. 323, 337 (2011).).

156. Gordon, *supra* note 19, at 679.

physical harm is imminent.[157] This argument essentially takes issue with a broad notion of dangerousness, divorced from an imminence requirement and reliant on fallible predictive methods.[158] By contrast, others criticize the criteria as too narrow, leaving people suffering on the streets because they are a threat to no one, yet clearly deteriorating.[159] This argument considers the deinstitutionalization movement of the 1960s as partially failed, as not enough resources have been devoted to community care to capture those in need of support and treatment.[160] The result, it is argued, is that only middle class people with less serious disorders have benefited from the shift to community-based treatment, and lower-income people living with more serious illnesses (although not necessarily dangerous) end up in jail and/or prison.[161] These criticisms boil down to policy choices, specifically whether to give primacy to therapeutic aims or individual liberties. Even if one believes (as I do)[162] that these criticisms implicate solutions of a degree, not kind, they have merit. It is outside the scope of this Article to wade into the criticisms but it suffices to say that there are no simple fixes to resolving them, nor for finding a perfect definition of dangerousness or standard by which to test for its presence.

Nevertheless, and despite its flaws, dangerousness as the governing standard is preferable to the alternatives. Commitment statutes require both the presence of mental illness and a consequence of the illness.[163] The alternatives are to change the consequence or remove it altogether. There is no viable consequence to authorize the use of the state's police power that does not immediately conjure an even more problematic application than dangerousness. Public welfare, health, safety, or some other similarly-themed standard would be subject to the same predictive and definitional issues as dangerousness but would cast an even wider net, and be much more likely to falsely capture even more people, contrary to the move away from deinstitutionalization. The other option would be to return to a regime where commitment standards do not require a consequence and rely solely on a "need for treatment" or

157. *See, e.g.*, D.H. Stone, *supra* note 155, at 326–30.

158. *Id.* at 325.

159. *See, e.g.*, Gordon, *supra* note 2, at 691–95.

160. *Id.*

161. *Id.* at 692–95; *see also* Jacobi, *supra* note 26, at 7.

162. Greenberg, *supra* note 26 (where I argue that artful drafting can resolve seemingly intractable doctrinal conflicts, such as whether professional discretion-oriented beneficence and legalism are mutually exclusive means to achieving therapeutic aims).

163. *See* Gordon, *supra* note 2, at 462–65.

similarly exclusively discretion-based threshold—a threshold rejected by the Court as running afoul of due process standards.[164] Neither option is feasible.

By contrast, the dangerousness standard emphasizes both the legal requirement of the provision of due process, and the corresponding necessity of balancing individual rights with broader societal interests. That balancing exercise limits intervention to only those circumstances where there exists a sufficiently strong governmental interest, such as the state's duty to protect society from a discernable, serious danger.[165] It also recognizes that civil commitment is a serious curtailment of civil liberties.[166] In short, the Fourteenth Amendment protects the liberty interests of the mentally ill; and any law impinging these rights requires, as Bruce A. Arrigo writes, "reasonably clear guidelines" as to their reach.[167] In the duty to protect context, commitment may not be appropriate in every situation but it is implicit that some type of intervention is required. That intervention may indirectly trigger infringements of the individual's liberty. For instance, informing authorities of a potential threat may invite an individual to be detained for questioning. Thus, the risk in divorcing dangerousness from the duty to protect is that it would invite indirectly what would be impermissible directly.

To the last point, it must also be remembered that dangerousness is a construct, introduced for legal purposes, not medical ones. The development of the expertise of predicting future dangerousness arose out of the justice system's need for evidentiary support in commitment determinations.[168] As Michael A. Norko and Madelon V. Baranaski write:

> [T]he need [for predicting dangerousness] did not arise as a result of clinical experience or wisdom, or of empirical evidence, or even the quest for testable hypotheses about human behavior and its antecedents. It arose out of pragmatic needs for criteria to make distinctions between patients appropriate for inpatient or outpatient treatment, or for voluntary or involuntary treatment, when those became real choices in the 1960s and

164. *See, e.g.*, O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).

165. Freedman, *supra* note 5, at 265.

166. *See, e.g.*, D.H. Stone, *supra* note 155, at 325.

167. ARRIGO, *supra* note 18, at 11 (referring to the hazy, imprecise language often used to define the meaning of "mental illness," although the point applies equally to the broader notion that clear guidelines are required).

168. Gordon, *supra* note 2, at 672.

1970s.[169]

All of which is to say that regardless of whether dangerousness was intended to be a part of the *Tarasoff* analysis, it was designed for it. Specifically, it was designed to justify intervention on an objective basis. To the extent that it remains a flawed threshold for action, it bears emphasizing that an imperfect tool is better than no tool at all. Absent dangerousness, mental health providers face even greater difficulty performing their dual functions as healthcare providers and society's protectors, and the difficulty undermines the autonomy and liberty interests of those they care for.

III. *VOLK V. DEMEERLEER*

A. Volk v. DeMeerleer*: The Reignition of the Duty to Protect "Anyone" Foreseeable*

On July 18, 2010, Jan DeMeerleer entered the home of his ex-girlfriend, Rebecca Shiering, and killed her and one of her sons; he attempted to kill another but the boy fended him off, fled and survived; DeMeerleer later killed himself.[170] DeMeerleer had a long history of depression and bipolar disorder, and obtained treatment on an intermittent basis between 2001 and 2010 from Dr. Howard Ashby at the Spokane Psychiatric Clinic.[171] Over the years, DeMeerleer expressed suicidal and homicidal thoughts to Ashby, the latter of which were never against his victims nor said in years.[172] The last homicidal thought on record was in 2003 and directed toward his ex-wife, seven years before the index offense.[173] There were a few disturbing instances implying a potentially violent streak, including striking one of Shiering's young sons on one occasion, but otherwise no history of violence.[174] On April 16, 2010, during what would be his last visit with Ashby, DeMeerleer was struggling; he had lost his job and Shiering had left him; he expressed suicidal thoughts but denied an intention to act on it.[175] Four months later he committed the index offenses.

---

169. Michael A. Norko & Madelon V. Baranoski, *The Prediction of Violence: Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTIONS 73, 73 (2008).

170. *See* Volk v. DeMeerleer, 184 Wash. App. 389, 394, 337 P.3d 372, 374 (Wash. Ct. App. 2014).

171. *Id.* at 395–96, 337 P.2d at 375.

172. *Id.* at 395–407, 337 P.2d at 375–81.

173. Volk v. DeMeerleer, 187 Wash. 2d 241, 386 P.3d 254 (2016).

174. *Volk*, 184 Wash. App. at 417, 337 P.2d at 386.

175. *Id.* at 405, 337 P.3d at 380.

Sheiring's mother, Beverly Volk, and her surviving sons (together, "Volk"), sued Ashby and the Clinic for, *inter alia*, medical negligence,[176] alleging failure to asses DeMeerleer's suicidal and homicidal risk and provide treatment.[177] Volk alleged that Ashby "might have prevented the attack" by mitigating DeMeerleer's dangerousness or warning the victims.[178] Ashby and the Clinic moved successfully for summary judgment dismissal on the grounds that they did not owe a duty to anyone in general or the victims in particular since DeMeerleer never threatened them in Ashby's presence.[179] Volk appealed, relying on *Petersen* and arguing that it was applicable and it did not require actual threats to an identifiable person before the duty arose.[180]

A majority of the Court of Appeals agreed with Volk, and in so doing, re-introduced *Petersen*'s duty to protect "anyone foreseeable" to Ashby.[181] It set out two issues on appeal. The broad issue was what duty is owed by a mental health professional to protect a third party from the violent behavior of the professional's patient or client. The narrow issue was whether professionals hold a duty to protect a third person, "when an outpatient who occasionally expresses homicidal ideas, does not identify a target."[182] Notwithstanding its acknowledgement that *Tarasoff* was subsequently limited, that *Petersen* was the extreme extension of that case, and that section 71.05.120 of the Revised Code of Washington was amended explicitly to curtail *Petersen*, the majority held that the "limited duty to warn" identifiable individuals applied only to professionals in the involuntary commitment/inpatient setting; it did not preclude a broader duty in the outpatient setting.[183] In its view, the state legislature saw fit to protect professionals in the one context but not the other.[184] It also affirmed the summary judgment of Volk's claim to the extent it related to Ashby's failure to take steps to commit DeMeerleer.[185]

---

176. *Id.* at 394, 337 P.3d at 374. Other claims, which are outside the scope of this paper, include medical malpractice, loss of chance, wrongful death, loss of family members, and emotional harm resulting from the attack. *Id.*

177. *Id.* at 407, 337 P.3d at 381.

178. *Id.* at 407–08, 337 P.3d at 381–82.

179. *Id.* at 408, 337 P.3d at 382.

180. *Id.* at 413–14, 337 P.3d at 384.

181. *Id.* at 425–26, 337 P.3d at 390.

182. *Id.* at 413, 337 P.3d at 384.

183. *Id.* at 425–26, 337 P.3d at 390.

184. *Id.* at 426, 337 P.3d at 390.

185. *Id.* at 425, 337 P.3d at 389.

Associate Chief Justice Brown dissented, concluding that the historical development of section 71.05.120 of the Revised Code of Washington narrowed *Petersen* in full and applied in all contexts, outpatient and inpatient alike.[186] Justice Brown also reasoned that the duties owed under subsection (1)—to act in good faith and not with gross negligence—applied to any person reasonably foreseen to be endangered by the patient; whereas the "duty to warn or take reasonable precautions to provide protection" applied only to identifiable victims.[187] Volk's allegations were limited to the latter provision, and thus outside the scope of the duty.[188] In Justice Brown's view, the statute clearly applied to the common-law duty, as both *Petersen* and the provision used the same language, namely "reasonable care to protect."[189] Ashby and the Clinic appealed.

B. The Washington State Supreme Court Denies the Relationship Between the Duty to Protect and Dangerousness

The Washington State Supreme Court upheld the "anyone foreseeable" standard but it departed from the appellate court below in its reasoning. Rather than engage with the role and meaning of section 71.05.120 of the Revised Code of Washington, the Court focused on the presence of a "special relationship" between Ashby and DeMeerleer as the singular and definitive basis for recognizing the presence of a duty to protect. Justice Fairhurst, writing for a five-person majority, relied heavily on *Tarasoff* and *Petersen*, and those cases' reliance on section 315 of the Restatement (Second) of Torts.[190] Justice Fairhurst stated that *Tarasoff* relied solely on an expansive reading of section 315, and was "not based on a hypothetical ability to control the patient."[191] In support of that position, Justice Fairhurst reviewed a number of control-based precedents and rejected each as applicable to the circumstances.[192] *Petersen* was, in her view, "the most relevant analog to the present case," and under that case, once a special

186. *Id.* at 438, 337 P.3d at 396.

187. *Id.*

188. *Id.* at 440, 337 P.3d at 397.

189. *Id.* at 440–41 & n.4, 337 P.3d at 397.

190. Volk v. DeMeerleer, 187 Wash. 2d 241, 255–56, 386 P.3d 254, 262–63 (2016).

191. *Id.* at 257–58, 386 P.3d at 264.

192. *Id.* at 257–58, 386 P.3d at 264–65. All of the cases were outside the mental health law context, dealing with analogous circumstances such as the dynamic between parole officer and parolee.

relationship is formed, a duty exists without regard for the "control" principle.[193] After all, Her Honor held, the "nature of the relationship in *Petersen* gave the doctor unique insight into the potential dangerousness of his patient as well as the identity of the potential victim."[194] Accordingly, where the special relationship exists, the "*Petersen* duty" applied, even in the outpatient setting.[195]

Justice Fairhurst then weighed the policy considerations impacting whether to impose the duty. First, the inability to control a patient was rejected as militating against the duty on the basis that a number of other measures can be taken without it (though none were listed).[196] Second, the public's interest in being safe from assault weighed in favor of imposing the duty, as mental health professionals (MHPs) were the means by which "to identify and control such risk."[197] Reference was made to section 71.05.120 of the Revised Code of Washington for support of the professionals' "broad responsibility to protect society against the dangers associated with mental illness."[198] Third, the concern about accurately predicting whether a patient represents a "substantial risk of physical harm to others" did not undermine imposition of the duty since the expectation was not perfection but rather the "standards of the mental health profession [required] to arrive at the informed assessment of their patients' dangerousness." Justice Fairhurst observed that "if predicting a patient's dangerousness without at least some amount of accuracy was not possible, MHPs would not be entrusted to do so for civil commitment."[199] Fourth, the expansive duty's threat to the twin goals of placing the patient in the least restrictive environment and safeguarding patients' rights to be free from unnecessary confinement was downplayed, if not denied altogether. Justice Fairhurst acknowledged *O'Connor*, and the constitutionally-protected liberty interests of individuals, as well as the fact that institutionalization was not meant to serve as grounds for "dumping . . . people whose behavior might prove to be . . . offensive to society."[200] Nevertheless, the concerns tied to patients' rights and interests were not borne out according to

193. *Id.* at 259–60, 386 P.3d at 265.

194. *Id.*

195. *Id.* at 261–62, 386 P.3d at 266.

196. *Id.* at 263–64, 386 P.3d at 267–68.

197. *Id.* at 264, 386 P.3d at 268.

198. *Id.*

199. *Id.* at 265–66, 386 P.3d at 268–69.

200. *Id.* at 267–68, 386 P.3d at 269–70.

various scholarly references and case law, including *Lipari*.[201] Therefore, that issue also favored imposition of the duty. Finally, concerns about the breach of patient confidentiality were rejected on the basis that the protection was "conditional and will yield to greater social interests e.g., 'to protect the patient or the community from imminent danger.'"[202] Justice Fairhurst went on to state that as to balancing the outcome, failing to recognize the duty owed by therapists to foreseeable victims "would foreclose a legitimate cause of action and would inform the victims that their rights are not worthy of legal protection against the dangerous conduct of mental health outpatients."[203]

As applied to Ashby, who conceded that he and DeMeerleer had a special relationship, Justice Fairhurst emphasized that Ashby knew DeMeerleer had suicidal and homicidal thoughts, had attempted suicide and other violence at different times, and appeared unstable at their last meeting.[204] Nevertheless, Ashby did not arrange a follow-up appointment nor did he take other steps, such as performing risk assessments.[205] Further, Her Honor wrote, although DeMeerleer did not identify his victims, *Petersen* did not require that he do so.[206] Summary judgment was therefore inappropriate and thus, a genuine issue of material fact remained as to whether DeMeerleer's actions were foreseeable.[207]

Writing for the dissent, Justice Wiggins challenged the majority's relationship-driven, control-free analysis as "unheralded,"[208] and contrary to the explicit language of the Restatement[209] and the case

201. *Id.* at 268, 386 P.3d at 270.

202. *Id.*

203. *Id.* at 273–74, 386 P.3d at 272.

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

208. *Id.* at 275, 386 P.3d at 281 (Wiggins, J., dissenting). Indeed, the issue of control was not briefed by the parties or amici. *See* Petition for Review, Volk v. DeMeerleer, 187 Wash. 2d 241, 386 P.3d 254 (2016) (No. 91387-1); Volk's Answer to Howard Ashby, M.D.'s Petition for Review, *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1); Brief of Amici Curiae Victim Support Services the National Alliance on Mental Illness (NAMI)-WA, *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1); Brief of Amicus Curiae Washington Defense Trial Lawyers, *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1); Brief of Amici Curiae Washington State Medical Association, et al., *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1); Brief of Amicus Curiae Washington State Association for Justice Foundation, *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1).

209. Section 315 reads: "There is no duty *to so control the conduct of a third person . . . unless* . . . a special relation exists.") (emphasis added). *See* RESTATEMENT (SECOND) OF TORTS § 315 (AM. LAW INST. 1965).

law—including its own very recent decision, *Binschus v. Department of Corrections*.[210] That case emphasized the notion of control in applying the duty[211]—which meant *Volk* represented an unsupportable broadening of the duty owed to third parties.[212] From its vantage point, the majority eschewed section 315 in favor of adopting section 41 of the Restatement (Third) of Torts: Liability for Physical and Emotional Harm, despite the latter having yet to be adopted by any state (it has only been rejected), and without full and due consideration.[213] The dissent would have affirmed the summary judgment dismissal.[214]

C. Volk: Unsupportable, Unworkable, and Contrary to Policy

With *Volk,* the Washington State Supreme Court has once again imposed on therapists a duty to protect *anyone* who might foreseeably be harmed by a patient, creating in essence, a duty to protect all of society rather than specific, identifiable individuals. The majority decision is problematic on many fronts—it is contrary to law, policy, and common sense. It places therapists in an even more untenable position than *Petersen* did insofar as it requires only the presence of a special relationship between patient and therapist and nothing more, namely dangerousness. In so doing, it prioritizes the interests of a hypothetical, unknown class of potential victims at the expense of the rights and interests of mentally ill persons—an unheralded departure in mental health law policy that was decades in the making.

Among the primary issues with the majority's legal analysis is its blinkered reliance on *Petersen* and its position that a special relationship was all that was required to establish the duty. First, *Petersen* is far from being "the most relevant analog" to *Volk*. Knox was a drug addict in violation of his parole and he exhibited dangerous behavior the day before he was discharged from involuntary commitment.[215] Knox was doubly subject to state control, as an inpatient and as a parolee, and the therapist was found to be grossly negligent in her management of

210. 186 Wash. 2d 573, 380 P.3d 468 (2016).

211. *Binschus*, 186 Wash. 2d at 577–79, 380 P.3d at 471, 473 (2016) (concerning state liability for the crimes of a recently released inmate, the Washington State Supreme Court affirmed summary judgment dismissal, emphasizing that the nature of the duty was to control the third party's conduct).

212. Volk v. DeMeerleer, 187 Wash. 2d 241, 386 P.3d 254, 275 (2016).

213. *Id.* at 286–87, 386 P.3d at 278.

214. *Id.* at 288–89, 386 P.3d at 279.

215. Petersen v. State, 100 Wash. 2d 421, 422–24, 671 P.2d 230, 234–36 (1983).

Knox.[216] By contrast, DeMeerleer had not exhibited or indicated troubling behavior in more than six years, and was not seeking treatment as an inpatient.[217] Nor was Ashby subject to an allegation of gross negligence; the summary dismissal of allegations related to Volk's negligence claim that commitment proceedings should have been initiated was affirmed on appeal.[218] Further, as stated in the dissent, there was no basis for denying control's relevance to the analysis. Its presence, as illustrated in the case law discussion above, indicates the therapists' knowledge of the threat the patient poses—knowledge, the majority suggested, exists without it.

This leads to the erroneous view that *Tarasoff* relied "solely" on section 315. As set out above, that case emphasized foreseeability as the most important criteria and, regardless of the outpatient context, the danger was clearly foreseeable; there was a specific threat to an identifiable victim and efforts to commit the patient were made. The California court may have relied on section 315 as authority for creating a relationship necessary to attach a duty to protect, but it was far from the only basis for doing so. In addition, it belies reason that the *Volk* majority, which repeatedly acknowledged *Petersen*'s involuntary commitment context, did not address its curtailment by the Washington State Legislature with the amendment of section 71.05.120 of the Revised Code of Washington. There is no question that that provision was intended to narrow *Petersen*.[219]

Associate Chief Justice Brown had the correct interpretation; at the very least, it is the one consistent with the development of the duty to protect. He found that the duties owed under section 71.05.120(1) of the Revised Code of Washington—to act in good faith and not with gross negligence—applied to any person reasonably foreseen to be endangered by the patient; whereas the "duty to warn or take reasonable precautions to provide protection" under section 71.05.120(2) of the Revised Code of Washington applied only to identifiable victim(s). This is the codification of *Currie v. United States*: no broad duty to the public exists absent egregious circumstances of bad faith or gross negligence; only when a specific threat is made to an identifiable victim does the duty to

---

216. *Id.* at 438, 671 P.2d at 242.

217. *See* Volk v. DeMeerleer, 184 Wash. App. 389, 394–407, 337 P.3d 372, 374–81 (Wash. Ct. App. 2014).

218. *Id.* at 423–24, 337 P.3d at 389.

219. *See* Freedman, *supra* note 5, at 256, 276 (describing Wash. Rev. Code § 71.05.120(2) as the legislature's "recent attempt to limit *Petersen* by amending the *relevant* mental health laws," with reference to discussions with state government authorities).

protect involve action beyond the commitment process. Otherwise, therapists would be held to a standard of care requiring use of a crystal ball.

From a clinical perspective, the decision is equally faulty. The majority suggests that there are a number of "preventative measures" that can be undertaken to satisfy the duty, but apart from initiating commitment proceedings and warning victims, or their family and friends, or the authorities, none are provided.[220] Warnings and/or informing others are only possible when victims are identified but none were identified in *Volk* (nor in *Petersen*, for that matter). There is no one to warn when no one is identified. Beyond that, authorities cannot take steps to protect "anyone foreseeable." Even if one could, hypothetically, conceive of warning people in the patient's life to prevent harm to "anyone foreseeable," privacy laws would not permit disclosure. Under section 70.02.050 of the Revised Code of Washington, disclosure is only permitted if it will avoid or minimize an imminent danger to the health or safety of the patient or another individual.[221] Likewise, the federal privacy statute, the Health Insurance Portability and Accountability Act, permits disclosure of information arising under a patient-therapist relationship only where there exists a "serious and imminent threat."[222] The majority described the privacy protection as "conditional and yield[ing] to greater societal interests."[223] However, that position fails to acknowledge that both state and federal legislatures circumscribed those conditions to instances where there is an imminent threat to an individual. The duty goes well beyond that, to situations which do not rise to the "serious and imminent" threshold.

In addition, in failing to reconcile *Petersen* and section 71.05.120 of the Revised Code of Washington, there now exist two duties to protect—one for professionals operating in the outpatient setting and one for those operating in the inpatient setting. Two issues immediately arise: First, what standard applies to a professional who operates in both settings? It is unclear. Second, how can the more onerous duty apply to those with less control and corresponding authority to act, even putting aside the statutory references to the contrary? Again, it is unclear. Beyond that, *Volk* places the outpatient-oriented professional in a catch-22: if he discloses his patient's confidential information or initiates involuntary

220. Volk v. DeMeerleer, 187 Wash. 2d 241, 265–66, 386 P.3d 254, 268 (2016).

221. WASH. REV. CODE § 70.02.050(c) (2016).

222. 45 C.F.R. § 164.512(j) (2016).

223. *Volk*, 187 Wash. 2d at 269–70, 386 P.3d at 270.

commitment proceedings to avoid the risk of liability to a third (unknown) party for failure to protect, he faces liability from his patient for breach of confidentiality or unlawful confinement; if he does neither, the exposure simply reverses. Whichever path he chooses, the therapist is exposed to liability.

Perhaps most disconcerting for practitioners is that there is no clear "trigger" upon which they are required to act. In their amici curiae brief in support of reconsideration of the majority decision, various state and national healthcare clinicians and hospital associations, whose members provide mental health services, point out that the duty arises automatically upon establishment of a relationship.[224] There is no event or circumstance to demonstrate the presence of, in their words, "an imminent threat of serious harm."[225] No temporality exists, and therefore, no direct cause for intervention arises. That is, the majority removes the precondition of, in a word, dangerousness.

But a broader, more pernicious problem arises: the denial of protection from unwarranted intervention born from the dangerousness standard. Alan Stone wrote of *Tarasoff*, "[T]here is little evidence in either [*Tarasoff*] decision of any recognition of the policy of protecting the rights of patients."[226] Indeed, the emphasis is entirely on public safety.[227] The same is true of *Volk*. As much was made clear from Justice Fairhurst's statement justifying the overriding of patient confidentiality laws on the basis that to do otherwise "would inform the victims that their rights are not worthy of legal protection against the dangerous conduct of mental health patients."[228] This statement speaks volumes because the *Volk* duty denies the necessity of dangerousness in the analysis altogether. Rather, from the vantage point of the patient, it is presumed that if she has a mental illness and a "definite, established and continuing" relationship with a therapist, she is necessarily a danger to others, and therefore subject to intervention of some kind at any time. Dangerousness then is a state of being rather than a construct—an approach repugnant to the precedents of *Lessard v. Schmidt*, *Jackson v. Indiana*, and *O'Connor v. Donaldson*. It is also plainly contrary to the trends in *Tarasoff*'s progeny emphasizing foreseeability and control—

224. Brief for Washington State Medical Ass'n, et. al., as Amici Curiae Supporting Petitioners, *Volk*, 187 Wash. 2d 241, 386 P.3d 254 (No. 91387-1).

225. *Id.* at 3.

226. Alan A. Stone, *The Tarasoff Decision: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 363 (1976).

227. *Id.*

228. *Volk*, 187 Wash. 2d at 272, 386 P.3d at 274.

components indicating the presence of dangerousness.

It is also troubling the degree to which the majority denies the potential impact of its ruling on the pressure to increase commitment proceedings. Justice Fairhurst denied that the original *Tarasoff* duty to protect led to increased commitment proceedings,[229] which may be true, but it is hardly because that ruling and *Petersen*, in particular, were not serious threats to that development. Rather, those precedents were curtailed by subsequent cases such as *Thompson v. County of Alameda*[230] and *Currie v. United States*[231] and legislative amendments such as section 71.05.120(2) of the Revised Code of Washington. In fact, the Fourth Circuit acknowledged in *Currie,* without an identifiable victim, commitment is the only option.[232] And, as the Soulier review reported, some practitioners see commitment as preferable to breaching confidentiality obligations.[233]

At the very least, the decision declares a winner between therapists' dual roles treating the mentally ill and protecting society from the harm some may pose. It gives first position to anonymous, unknown, potential victims to whom no threat may ever be made or contemplated. Therein lies the rub: after decades building a legal framework that honors the rights and interests of the mentally ill, including establishing criteria for intervention that is a reasonable compromise between the hampering of their autonomy and the risk to society's safety, *Volk* appears to suggest that the compromise is malleable rather than a constitutional requirement. The effect villainizes a class of people for the acts of a few that are no more foreseen than random acts of violence by someone not in treatment and therefore not subject to the same scrutiny.

CONCLUSION

With *Volk v. DeMeerleer*, the Washington State Supreme Court has once again invited serious scrutiny of the duty to protect third parties from mentally ill persons. That decision, like its predecessor, *Petersen v. State*, protects anyone foreseeably harmed by a dangerous patient—except that the nature of the relationship between the therapist and patient is determinative, rather than the legal criteria of foreseeability and dangerousness. The result does away with the objective criteria

229. *Id.* at 268, 386 P.3d at 270.

230. Thompson v. Cty. of Alameda, 615 P.2d 728 (Cal. 1980).

231. Currie v. United States, 836 F.2d 209 (4th Cir. 1987).

232. *Id.*

233. *See* discussion in Soulier et al., *supra* note 80, at 459–61.

requiring intervention, namely the existence of a threat of serious and/or imminent harm to an identifiable individual(s) (i.e., dangerousness). This Article has argued that the consequences for this shift are significant: it creates bad law, jeopardizes good clinical practice, and most importantly, undermines the legalist, rights-based model of mental health law ushered in midway through the twentieth century.

It must be remembered that dangerousness is a construct, not a state of being, and the duty to protect cannot operate fairly without it. By emphasizing the nature of the relationship between therapist and patient, rather than the presence of dangerousness, the message to the mentally ill is clear: you are inherently dangerous to others, and subject to state interference at any time. Not only is this contrary to constitutional precedent, it plainly contradicts the principles of autonomy and liberty underlying those historic cases. *Volk* invites a return to discretion-based treatment that denies persons with mental illness their rights; after all, *Volk* requires action before the due process associated with dangerousness is triggered. But the consequences go further: it is a regression to a time when the mere presence of mental illness was considered a threat to society, and those suffering were menaces warranting premature interference.

In short, the *Volk* decision divorces dangerousness from the duty to protect, and it does so at the expense of the patient. However tempting it may be to deny due protection in the name of public safety, particularly in the face of gruesome crimes such as those committed by DeMeerleer, the judiciary and society generally ought not to conflate the rare actions of some with the states of mind of all. We ought not to presume that such actions are necessarily foreseeable—and therefore preventable—in the first place. Accordingly, *Volk* cannot remain good law. A motion for reconsideration was denied, and bills drafted for the 2017 state legislature session failed to pass.[234] The current state of affairs cannot stand. Absent an unequivocal correction and clarification by the bench that "something more"[235] is required than the mere presence of an ongoing therapeutic relationship, the legislature must act, lest the pendulum swing forcefully backwards.

234. H.B. 1810, 65th Leg., 2017 Reg. Sess. (Wash. 2017); S.B. 5800, 65th Leg., 2017 Reg. Sess. (Wash. 2017).

235. O'Connor v. Donaldson, 422 U.S. 563, 576 (1975).