International Journal of Emergency Mental Health and Human Resilience,Vol.23, No.6, pp 86-92 © 2021 OMICS International ISSN 1522-4821

Tarasoff vs Threat: Considerations for Mental Health Providers Navigating Legal, Ethical and Practical Variables Associated with Preventing Mass Acts of Violence

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ABSTRACT: *Protecting patients and communities is a serious concern for counselors and the rest of the mental health community. The process of violence must be interrupted before events occur. Every day, mental health workers must navigate complex ethical territory regarding confidentiality and their Duty to protect potential victims from targeted violent acts. Federal agencies responsible for ensuring privacy and other professional organizations provide guidance to assist in this critical process. A review of multiple factors significant during the application of these standards provides insight to the mental health community tasked with navigating ethical and logistical concerns during critical moments when working with potentially lethal patients. Through a stronger understanding of the differences between general threat and targeted threat assessments, state and ethical limitations and expectations regarding threats, elements present in imminent threats and the power of collective intelligence gained by collaboration, interdisciplinary care and the reduction of siloed mental health care, and increased community connections, the mental health community can increase its effectiveness at managing potential targeted threats, interrupting the process of violence and decreasing lethal actions.*

Keywords: *Tarasoff, Mass Shooting, Mental Health, Duty to Warn, Duty to Protect, Ethics*

While mass shootings account for less than 1% of homicide in our nation (Peterson & Densley, 2020), their egregious nature and impact within a community and nation creates an outsized influence on society (Luca et al., 2020). The ripple effect from these events have included 15% increases in proposed gun legislation (Luca et al., 2020) the year following an event, new conversations and guidance for health workers regarding privacy laws, safety protocols within schools and communities as well as training for citizens. Increased emphasis has been placed on the role mental health care plays in keeping communities safer from these actors. Violence is a process that must be interrupted before adverse events occur within our communities. While many attempt to homogenize the causes of these events down to legislative solutions and single factors, the complexity of human behavior as heinous as mass murder will require a multi-faceted approach. It's been said that when the only tool one has is a hammer, every problem appears to be a nail. It is natural for legislators to attempt to use their hammer, behavior health to use their saw, etc. However, it is in the collaboration of all the available stakeholders through interdisciplinary strategies and proactive communication that communities will begin to see significant change.

This paper will focus on what the mental health care community can do to fulfil their duty to attempt to increase public safety in specific-threat scenarios. Peterson & Densley (2020) compiled extensive data on mass shootings from 1966 to 2020. For the purpose of data gathering, mass

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shooting events were defined by the Congressional Research Service (Krouse & Richardson, 2015) standard of 4 or more victims killed with firearms, within one event, in public locations geographically close to each other that are not attributed to other underlying criminal activities (i.e., armed robbery, criminal competition, romantic triangle). An examination of their comprehensive mass shooting dataset highlighted the critical role mental health care providers had with many of these mass killers (Peterson & Densley, 2020). Further investigation of mental health components related to the118 individuals who committed mass shootings in the United States between 1995 and 2020 (Peterson & Densley, 2020) was examined. Of those individuals, 84.7% showed signs of crisis with 70% having a diagnosable or diagnosed mental illness. At least 33.9% of those individuals have received counseling services, 30.5% received psychotropic medication for their illness and 21.1% had been previously hospitalized for care. Psychosis was reported in 43.4% of those actors with a mental illness and found to have played a role in all of their acts, 30% of the 118 individuals. Of significance, 29 of them had received treatment (i.e., counseling – 72.5%, medication – 80.5%, etc.) within the 6 months prior to their homicidal act. These findings reveal the important role the mental health community has in keeping communities safer, and the urgency expressed by professional organizations, state legislators and those responsible for protecting the privacy of those within the care of mental health care professionals.

LEGALITIES AND ETHICAL CONCERNS

Protecting clients and communities is a serious concern for counselors and supervisors. In light of more than forty years of *Tarasoff* (*Tarasoff* v. Regents of University of California - 17 Cal. 3d 425 - Thu, 07/01/1976 California Supreme Court Resources, n.d.) being codified into States' laws, there are numerous ethical challenges that require constant attention. This 1974 ruling initiated the duty to warn "foreseeable" victims in specific-threat situations. This decision received strong enough backlash for the California Supreme Court to two-years later, hear the case a second time where the language was amended from the duty to warn to a duty to protect. They wrote, "When a therapist determines 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 warn the intended victim, to notify the police, or to take whatever steps are reasonably necessary under the circumstances." The judges added alliteratively, "The protection privilege ends where the public policy begins." (Harvard Health, n.d.) Protecting clients and communities is a serious concern for mental health professionals. Every day, they must navigate complex legal and ethical territory regarding compliance and confidentiality. Compliance can be problematic as each state has their own interpretation, limitations and guidelines regarding this duty in these situations. It is imperative that providers become familiar with their specific state laws as they vary significantly between states (The authors of this paper are not lawyers and recommend that mental health professionals seek legal consultation regarding their specific legal boundaries and duties).

The Commonwealth of Virginia provides immunity to mental health service providers in their duty to take precautions to protect third parties from serious harm when a client communicates a 'specific and immediate threat to cause serious bodily injury or death to an identified or readily identifiable person or persons' (Code of Virginia (§ 54.1-2400.1.)). Virginia further qualifies that this duty does not attach if the threat is not direct to the provider while engaging in professional duties. It also provides immunity for "reasonably available" steps taken to prevent the client from using physical violence or other means to harm others "until the appropriate law-enforcement agency can be summoned and takes custody of the client" (Code of Virginia (§ 54.1-2400.1.4)). In contrast, a 2004 decision by the California appellate court upheld the landmark Ewing v. Goldstein case that increased the scope of the duty to protect for mental health provider's beyond specific threats observed in direct clinical services with their patients/clients to include a duty to act on communication from third parties, particularly from family members if the information leads the therapist to believe or predict the patient/client poses a serious risk of grave bodily injury to another (American Psychological Association, n.d.). In their response to Ewing vs. Goldstein, the American Psychological Association (APA) suggested the adverse effects of the Court of Appeal's decision to extend the duty to protect to third-party reports would, "undermine existing therapeutic relationships, deter potentially dangerous individuals from seeking treatment, prevent full-disclosure of patient's thoughts" while potentially resulting in, "over assessment of dangerousness" reporting that, "more threats are made than acted upon" (American Psychological Association, n.d.).

This contrast highlights the variability of interpretations and applications established in various states and the challenges these can make for mental health providers regarding assessment and decision-making dilemmas.

Mental health professionals must also navigate the complex trade-off between confidentiality (American Counseling Association [ACA], 2014, B.1.c) and their duty to protect (ACA, 2014, B.2.a). Federal agencies responsible for ensuring privacy and professional organizations provide guidance to assist professionals in this critical process (Drabant & HHS Office of Civil Rights, 2013; HIPAA Helps Mental Health Professionals to Prevent Harm, n.d.). The American Counseling Association (ACA, 2014) speaks to this duty defining scenarios as 'serious and foreseeable harm' (B.2.a.) and release counselors from the general requirement to keep information confidential when

disclosure is required to protect clients or identified others from serious and foreseeable harm or if they have any doubt about the exception, where consultation with other professionals is allowed (B.2.a.). The APA allows disclosure of confidential information without consent of the individual as mandated by law or was permitted for valid purposes such as protecting "the client/patient, psychologist or others from harm" (American Psychological Association).

The Health Information Portability and Accountability Act (HIPAA, 2021) governs health care workers' use and protection of patient information in *Tarasoff*-type situations through their Privacy Rule 45 CFR § 164.512(j) which states that a covered entity (provider) may act consistently with applicable laws and ethical codes to use or disclose protected health information to a person or persons who are reasonably able to prevent or lessen serious or imminent threats to the health and safety of a person or the public (p. 94-95). They further provided guidance for the mental health community stating that when *Tarasoff*-type events occur, the 'expertise and professional judgement' are to be used to determine the validity of threats, and if they are 'serious and imminent, can act without client permission to reach out to those who can prevent or lessen the risk' (HIPAA Helps Mental Health Professionals to Prevent Harm, n.d.). Additionally, they provide an example of a threat deemed to meet the criteria threshold for duty to protect response. An example is provided of a patient telling their psychotherapist that they are having 'persistent images of harming their spouse' and they state that the psychotherapist may notify the spouse, call their psychiatrist or primary care physician to review medications and develop a plan for treatment (i.e., voluntary or involuntary hospitalization or other treatment), call 911 if emergency intervention is required or notify law enforcement if needed (HIPAA Helps Mental Health Professionals to Prevent Harm, n.d.).

This example is unique as the 'serious' required is clearly met, yet elements necessary for imminence, even the level required to meet the criteria of acute hospitalization, may not be present in many states. In light of the mass shootings in Newtown, CT and Aurora, CO, Leon Rodriquez, the Secretary of Health and Human Services (2013) released a statement to provide further guidance on navigating the HIPAA Privacy Rule stating that HIPAA's Privacy Rule does not prevent mental health professionals from disclosing necessary information about a patient to law-enforcement, family members of the patient, or other persons, if the provider has a good-faith belief the patient presents a serious danger to himself or other people. He expounds that one is presumed to have good-faith belief when the belief is based on the "provider's actual knowledge (direct client contact) or reliance on credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person)" (Rodriguez, 2013), citing Privacy Rule 45 CFR § 164.512(j).

When responding directly to the question, what constitutes a "serious and imminent" threat, the Health and Human Services (2018) stated, "HIPAA expressly defers to the professional judgement of health professionals in making determinations about the nature and severity of the threat to health or safety posed to a patient" (OCR, 2018), adding that the Office for Civil Rights (OCR) would, "not second guess a health professional's good faith belief that a patient poses serious and imminent threat" (OCR, 2018). Informed by these guides and position statements, one could still agree to the weightiness of the tension caused by the struggle to balance client autonomy and duty to protect foreseeable victims. Mills et al. (2011) highlight that within the *Tarasoff* v. Regents of the University of California (1976) decision embedded a requirement to not only to assess clients fora propensity for violence, but rather to assess for specific targeted violence.

THREAT VS TARASOFF-SITUATION ASSESSMENTS

A vast majority of threat assessment training provided in the formal preparation process for counselors, social workers, psychologists, psychiatrists, nurses, school counselors and other providers emphasizes the best practices of a formal risk assessment involving empirically established risk factors utilizing various appraisal strategies and proven instrumentation (Borum & Reddy, 2001; Borum, 2000; Borum et al., 1993; Otto, 2000; Monahan, 1981) for a generalization toward all threats. Borum & Reddy (2001) poignantly expound that *Tarasoff* requires that mental health professionals assess whether or not a client is, "on a pathway toward a violent act, shifting away from, static, research-based correlations of violence to ideas, behaviors, and situational influences that might indicate intent, planning and preparation for a violent act".

In their book, Clinician's Guide to Violence Risk and Assessment, Mills et al. (2011) discuss several significant differences between standard violence and *Tarasoff*-type assessments. They point out that the 'duty-to-protect' is exclusive to the mental health provider's relationships with clients they are treating. There is generally a choice of whether to conduct a formal risk assessment or not, however when a mental health professional deems by their professional judgment that a client may pose a clear risk to an identifiable person or persons, a *Tarasoff* evaluation must be conducted at that time. The mental health professional is not at liberty to dismiss a client's indication that he intendsto leave the session and kill a coworker because the rate of homicide is statistically low for these types of actions. Also unique is the fact that longer-term violence risk focus more on general, long-term risk tendencies with no specificity within the community, while *Tarasoff* assessments focus on risks aimed at a specific person or population that are imminent in nature.

In the light of standard violence assessments, Borum & Reddy (2001) describe *Tarasoff* assessments as more deductive, relying heavily on clinical judgment as opposed to a broader array of factors. *Tarasoff* assessments are more of a fact-based inquiry than intuitive with an increased focus of exploration of strategies to gain a stronger understanding of *when* to intervene, *how* to do so, and *what* strategies to activate to keep the targeted individual or population safer.

TARASOFF ASSESSMENT

The primary shift of assessment strategy begins when the mental health professional receives an indication that a patient or client may pose a serious threat to a person or persons. At that point, that specific provider must remain in compliance with state laws that govern their practice as well as other guiding ethical codes and standards while determining whether or not there is a reasonable clinical concern about violence directed toward the identified or identifiable person's. This targeted violence indicates that there is an identified or identifiable victim prior to an attack (Borum et al., 1999; Fein & Vossekuil, 1998; Fein et al., 1995; Reddy et al., 2001). Borum & Reddy (2001) acknowledge two potential challenges counselors face at that moment: (1) determining where or not the client poses a serious risk of violence to another and, (2) if so, what risks may be reasonably necessary to protect the intended victim. They must ask, "In this situation, should I do something, and if so, what?" (Borum & Reddy, 2001; Borum, 1998a,1998b).

IMMINENT THREAT EVALUATION

Fein & Vossekuil (1998) point out the difference between making a threat and posing a threat. A threatening statement is not the only necessary factor to raise clinical concern. They state that making a threat is communicating intent to do harm, while posing a threat often involves engaging in behavior that demonstrates further planning or the building of capacity for a violent act. Borum and Reddy (2001) suggest that once engaged in *Tarasoff* assessment, a mental health professional would benefit from placing the focus of the assessment on behaviors that would come before any planned violent attack, or "attacker related behaviors." These could include the development of ideas and plans to commit a violent act toward the person that is a target or even acquiring the means or capacity for the violent act. They may even express that they determined details of the attack such as the time, place, and how they would gain access to the target. Behaviors are significant because they indicate planning and preparation for the act in our significant indicators of the client's direction of travel toward that act. They are likely the first indicator that further Tarasoff assessment is indicated (Borum et al., 1999; Fein & Vossekuil, 1998; Fein et al., 1995; Reddy et al., 2001). Borum and Reddy (2001) suggest that mental health professionals attempt to conceptualize and obtain a gauge of the client's risk as a dynamic path from idea to action. The essence of the imminence of a *Tarasoff* threat could be framed as asking the question, is my client on a pathway toward a violent act? And if so, how fast are they moving in that direction and where could the appropriate person intervene? (Borum et al., 1999; Fein & Vossekuil, 1998; Fein et al., 1995; Reddy et al., 2001) This factual focus on the desired outcome of protection crystallizes the demand for the mental health professional's duty expansion of *Tarasoff* II (1976), from the *Tarasoff* (1974) limited scope of warning the intended victim. The expansion from *warn* to *protect* facilitates a broader scope of appropriate actions at the disposal of the mental health community in their duty to accomplish the task of keeping a person or persons safer. They provide the mental health professional with a better picture of how imminent the threat may be and what action is necessary to stop or lessen the violent act. (Borum & Reedy, 2001).

ACTION

Borum and Reddy (2001) introduced an assessment for mental health providers to consider when required to conduct a *Tarasoff* evaluation: *A*ttitudes supportive of violence, *C*apacity to carry out the threat, *T*hresholds crossed in a progression of behavior, *I*ntent to act versus threats alone, *O*ther's knowledge of the client, and *N*on-compliance with strategies to reduce risk. These are not in a specific order of importance and are intended by the authors to be a framework for guiding a fact-based risk assessment in a typical clinical encounter.

A-ATTITUDES THAT SUPPORT OR FACILITATE VIOLENCE: One's attitude toward a given behavior can be a strong indicator of whether an individual will engage in a particular behavior or not. The strength and nature of their attitude toward an action can provide useful data to a mental health provider (Kuhl & Beckmann 1985; Andrews & Bonta, 2010), specifically if they demonstrate or express that they believe the violent act is circumstantially justified. The more they feel justified to commit the act and believe it will work the increased likelihood of the action. They may express enabling provocations from fantasies, their own narratives, psychosis or attribution bias that fuel their escalation toward the act.

C-CAPACITY TO CARRY OUT THE THREAT: The deductive, fact-based risk assessment would benefit from consideration of the client's capacity or means to carry out the act, particularly related to the imminence of the threat. This may include their intellectual capacity, physical ability, access to supplies, weapons, information, access to the target, opportunity, or other psychological and logistical needs. In his book, Rage of the random actor Korem, (2008), Dan Korem discusses his random actor profile profiling system. While not the scope of this paper, Korem identifies that most mass killers fit his random actor

profile. He contrasts individuals as predictable/controlled or unpredictable/unconventional who outside of their competence act confidently or fearfully. He states that how one walks is more important than how one talks; how they operate as opposed to communicate. He found those who demonstrated unconventional behaviors and operating out of fearfulness, often act out their rage in communities that are small to mid-sized, suburban and in environments which are often predictable, controlled and stable (i.e., schools, colleges, churches, post offices, etc.). The unconventional history of behaviors a client may have mentioned during their intake assessment may provide data while considering their level of capacity.

T - THRESHOLDS CROSSED IN PROGRESSION OF BEHAVIOR: It is helpful to the mental health professional conducting the *Tarasoff*-ACTION Assessment to explore the existence of a plan as well as actions the client may have already taken to further the plan. Attack-related behaviors, or actions that move the act of violence toward the intended target closer to a reality, are a significant indicator of where they may be on the pathway toward violence. The National Threat Assessment Center (2021) report of their analysis of plots against schools revealed planning behaviors involving weapon-related planning, attack execution plans, documented plans, research of prior attacks, attempted recruiting of others, choosing of clothing and music, surveilled targets and researched security measures, research of relevant topics, acquisition of gear including a prepped bag and engaging in video game plan for training and skill learning. Behaviors that are violations of rules or laws are of an increased interest as they indicate a willingness to engage in antisocial actions to achieve their goal. In conducting a risk inquiry, it is helpful to ask not only about the existence of a plan, but also about what steps the client may have taken to further that plan.

I – INTENT TO ACT VS THREAT ALONE: Knowing whether or not the client has intention to act on their plan involves more than the presence of a statement. The expression of a statement of an idea or thought to harm another person that is supported by the intent to act upon that thought increases the risk toward the targeted person or persons. Borum and Reddy (2001) add that a level of intent may be inferred directly from a high degree of specificity with the access to means to accomplish it, or from actions from the client that indicate commitment to the plan (including consideration and rejection of alternative ways).

O- OTHER'S KNOWLEDGE OF THE CLIENT: Kuhl & Beckmann (1985) notes that a key factor related to the activation of a planned behavior is the expected reaction they anticipate from others regarding that completed action. This can help with assessment as it can assist the mental health professional with developing an idea around the client's own attitude toward the violent act. William Dodson (2013), in his book, If Only I Had Known, writes that Luke Woodham, the school shooter from Pearl, MS, planned on tying his mother up and putting her in the closet while he stole her car to carry out his attack and was convinced by a friend to kill her instead. "So I did", Luke reported later, discussing how he stabbed her seven times and beat her to death with a baseball bat (p.15). In this case, the reaction from a friend reportedly influenced the escalated his behavior to be homicidal. In some cases, the justification for the act against the targeted person or persons may be strongly internally grounded while in other cases, an actor's perception may be more fluid and influenced by those around them. This influence may be encouraging/ enabling the future aggressive act or discouraging it through direct conversations and interactions or beliefs the actor may have of others' attitudes and reactions. Exploration of this idea will also reveal how influenced or justified their act may seem within social contexts (i.e., injustices, political fervor, etc.). Regardless, if the client discussed their plan for targeted violence, it would be good to know whether those individuals discouraged the act, condemned it, supported or escalated it, or even actively participated in moving the idea forward toward action (Borum and Reddy, 2001).

N- NON- COMPLIANCE WITH RISK REDUCTION INTERVENTIONS: Finally, a client's disinterest or lack of willingness to engage in the therapeutic process or comply with interventions to mitigate risks to their own behavior could be indicative of their location on the path toward the violent act. Attitudes toward therapy can be fuelled by beliefs and perceptions about the efficacy of treatment (i.e., refusal to comply with prescribed medication instructions, refusal to consider higher levels of care, missing appointments, etc.) Non-compliance may also present itself as reduced insight about planned behavior or the importance of treatment protocols for positive outcomes.

DISCUSSION

Ideally, the completion of the *Tarasoff* assessment would yield information useful in gaining an understanding of the types of interventions that may be necessary to protect targeted individuals. As indicated in the state laws, code of ethics and guidance documentation from those responsible for maintaining the privacy of our clients, there is a scope of actions that may release the provider from their duty. In an attempt to create safer communities by reducing heinous acts of mass violence and suicide, legislators have provided another tool for families and community members in the form of Extreme Risk Protective Orders (ERPO), better known as red flag laws. It is important to understand that these measures attempt to reduce lethality solely attempting to temporarily restrict an individual who is believed to pose a risk, access to one form of means, firearms. Means is only one part of the equation of concern for a fact-based *Tarasoff* assessment and may not be an indicator of movement down the path of violence (they may have safely possessed firearms for years). As Dershowitz (2019) noted in his ongoing fifty

years of studying the topic, "Research shows that any group of people identified as future violent criminals will contain many more who won't be violent (false positives) than who will (true positives). More true positives mean more false ones. Such groupings also fail to identify many future violent criminals (false negatives)."

The concern is that solely enacting an ERPO will provide a false sense that the threat has been removed (Lott and Moody, 2019). While this may disrupt the timing of the client's plan, it alone should not be considered an adequate plan to release the mental health provider from their duty. Within the mental health provider community, the duty to protect is restricted to clients/patients within the care of the provider. A provider, who through their professional judgement informed by a *Tarasoff*-type assessment, who deems their client/patient to pose a risk and is considering an ERPO needs to also consider that (1), the criteria has likely been met for a higher level of stabilization and care, which inherent provides a safer environment than simply removing known firearms from their existing environment and (2), the action of the ERPO likely will not suffice for the discharge of the duty to protect.

BARRIERS TO ACTING ON TARASOFF ASSESSMENT FINDINGS: There are many considerations when attempting to act upon the findings of an assessment. One of the primary concerns mental health professionals have to balance is the need to create safety for the targeted potential victim and the therapeutic alliance that is built on trust and rapport. While our wishes may be diffused, it is critical that we act in the highest degree of safety for all involved. We would be remiss if we did not explore the content necessary for these assessments to occur in the firstplace, a homicidal client that we are likely alone within a room. Fear for one's personal safety may be justified and could certainly be understandable. The development of a strategy to manage personal safety while fulfilling this duty is something which needs to be explored systemically within one's practice. The unique nature of the requirement for confidential treatment in mental health care can lead many providers into a place of isolation regarding client care.The lack of interdisciplinary practice can systemically lead to siloed care providing limited access to collaborative interactions on short notice such as a critical moment such as a duty to protect decision. It is highly advisable to seek professional consultation if time permits (Monahan, 1993). The proactive development of relationships between caregivers for individual clients can close gaps often present during key transitional care points.

The development of collaborative relationships for *Tarasoff* assessments before they are needed can streamline the process of rapidly receiving critical support to gain support in making the best decision for the moment. It is important to explore points of contact for other entities who may be the required response to lessen or stop a targeted act such as local law enforcement contact information, their response time to one's location during different times of the day, the process of transportation for an involuntary commitment, and other processes. Interprofessional team development can streamline policies and processes. One of the best practices of elemental health provision is to have one's client to identify their location at the start of any session and have the contact information nearby for their local emergency services response, their care support person who is nearby and other numbers necessary to intervene quickly should it be necessary.

One area collaboration may be uniquely important is if there is a question about the standards of interpretation or any considerations regarding state legislation or ethical standards surrounding boundaries of responsibility and duty as well as limitations or expansion of the scope beyond the case law. Making oneself aware of legislative expectations and the scope of duty can easily remove one concerning variable from the real-time equation and decision-making process. Of course, in-service training on ethical issues and assessment strategies for these types of scenarios are always helpful in counselor development.

CONCLUSION

There is no shortage of challenges for mental health care providers, especially when the balance is required between protecting client privacy and the therapeutic alliance and fulfilling their duty to protect individuals or the public at large. Through the development of a deeper understanding of the differences between general thread assessment and *Tarasoff* threat assessment, providers can gain confidence in their ability to discern the needed response for the moment, making the most sound decision they can in their best professional judgment to fulfil their duty to protect while supporting clients struggling with strong urges to engage in violent acts toward specific targets. Through collaborative relationships and avenues of connection within the community, counselors can make the best decision to make safety a priority and serve their patients.

Communities should find encouragement in the National Threat Assessment Center (2021) examination of sixty-seven targeted attack plots that were foiled by community members who were able to identify warning signs and took action to intervene. As mental healthcare professionals, we are on the front lines of this issue and have the tools and skills necessary to accurately assess and implement collaborative plans to be a part of the solution for targeted mass killings making each of our communities safer, one client at a time.

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