

AN EMPIRICAL EXAMINATION OF THE DANGEROUS PATIENT EXCEPTION

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*This Article empirically examines the effect of the dangerous patient exception to the psychotherapist-patient evidentiary privilege. The U.S. Supreme Court first recognized the psychotherapist-patient privilege in *Jaffee v. Redmond*. This evidentiary privilege prevents mental health professionals from testifying about confidential statements made by patients for the purposes of treatment. Since *Jaffee*, federal circuit courts have split on whether there should be an exception to this privilege in cases involving so-called dangerous patients that pose a serious risk to themselves or others. Central to this debate has been a disagreement among federal courts about whether the dangerous patient exception discourages vulnerable patients from receiving life-saving mental health treatment. While commentators have predicted that the U.S. Supreme Court may soon resolve this circuit split, no prior studies have empirically tested the effect of the dangerous patient exception.*

By taking advantage of the timing of this circuit split, we find that the introduction of the dangerous patient exception is associated with a statistically significant increase in suicides, but no change in homicides. Both results are consistent with claims by prominent critics, including the American Psychiatric Association, that the dangerous patient exception provides minimal public safety benefit while discouraging vulnerable patients from seeking mental health treatment. These results caution against recognizing or extending the dangerous patient exception in future cases.

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INTRODUCTION

In August of 1989, Lyle and Erik Menendez shot their parents to death in their Beverly Hills home.¹ The Menendez brothers claimed that they had experienced years of sexual abuse at the hands of their father.² They also alleged their mother was

¹ Tim Stelloh, *Menendez Brothers Timeline: A Look at the Murders, the Trials and the Efforts to Free Them*, NBC NEWS (Nov. 8, 2024), <https://www.nbcnews.com/news/us-news/menendez-brothers-timeline-trials-murders-free-prison-effort-rcna179362> [<https://perma.cc/NYH8-GGC5>] (“In the summer of 1989, Erik and Lyle Menendez burst into the den of their family’s Beverly Hills home armed with shotguns and opened fire, killing their mother and father.”).

² Cindy Von Quednow, Amanda Musa & Melissa Gray, *Los Angeles District Attorney Says He’ll Recommend Resentencing in Decades-Old Menendez Brothers’ Murder Case*, CNN (Oct. 24, 2024), <https://www.cnn.com/2024/10/24/us/>

an unstable alcoholic who made no efforts to stop the abuse.³ The Menendez brothers, who were eighteen and twenty-one at the time of the deaths,⁴ argued that they killed their parents in self-defense.⁵ They believed their parents were going to kill them to prevent the world from learning about the years of abuse.⁶ Prosecutors claimed that the killings were premeditated murders committed so that the brothers could inherit their parents' multimillion dollar estate.⁷

The national media extensively covered the brutal killings at the time, and the events have received renewed public interest with the release of Ryan Murphy's Netflix series *Monsters: The Lyle and Erik Menendez Story*.⁸ As part of the case against the Menendez brothers, prosecutors attempted to introduce

menendez-brothers-case-trial-now/index.html [https://perma.cc/B9HF-AU3N] ("However, they argued they should not be convicted because they acted in self-defense after enduring a lifetime of physical and sexual abuse by their father.").

³ Jaclyn Diaz, *The Menendez Brothers' Murder Case Is Getting a Fresh Look. Here's Why*, NPR (Nov. 25, 2024), <https://www.npr.org/2024/10/05/nx-s1-5140056/menendez-brothers-case-review-explained> [https://perma.cc/JH58-Z5EM].

⁴ *Id.* ("At the time of the murder the two men were 18 and 21.").

⁵ Stefanie Dazio, *Menendez Family Members Advocate for Brothers' Release as Prosecutors Review 1989 Murders*, PBS (Oct. 16, 2024), <https://www.pbs.org/newshour/nation/menendez-family-members-advocate-for-brothers-release-as-prosecutors-review-1989-murders> [https://perma.cc/S2G7-3HVS] ("But the brothers have said they killed their parents out of self-defense after enduring a lifetime of physical, emotional and sexual abuse from them.").

⁶ Stelloh, *supra* note 1 ("The siblings fatally shot their parents, they testified, after Lyle confronted Jose about his brother's abuse. When Lyle threatened to expose his father, he testified, Jose appeared to threaten him and his brother."); see also John Kapetaneas, Zach Fannin & Doc Louallen, *Menendez Brothers Murder Case Gets Reevaluated Based on New Evidence, Next Hearing in November*, ABC NEWS (Oct. 18, 2024), <https://abcnews.go.com/US/menendez-brothers-murder-case-gets-reevaluated-based-new/story?id=114814476> [https://perma.cc/AX3C-3ZD5] ("She argued that the brothers feared their parents would kill them if they disclosed the years of alleged molestation they had suffered at their father's hands.").

⁷ Courtney McGinley, *Lyle and Erik Menendez Break Silence in Netflix Doc: 'Washed' in Trial Two*, NEWSWEEK (Oct. 8, 2024), <https://www.newsweek.com/menendez-brothers-netflix-documentary-case-lyle-erik-1965708> [https://perma.cc/M3X3-ZDLH] (noting that prosecutors argued that the sons were motivated by a desire to inherit their parents' multimillion-dollar estate).

⁸ Selome Hailu, *Netflix Top 10: Menendez Brothers Series 'Monsters' Opens with 12.3 Million Views in Four Days—No. 1 on TV but Weaker than 'Dahmer'*, VARIETY (Sep. 24, 2024), <https://variety.com/2024/tv/news/netflix-top-10-streaming-ratings-1235697082> [https://perma.cc/4PXU-PDF7] (describing the widespread popularity nationally of the series upon initial release in 2024); Paul Tassi, *'Monsters: The Lyle and Erik Menendez Story' Dethroned in Netflix's Top 10 List by a New Show*, FORBES (Sep. 30, 2024), <https://www.forbes.com/sites/paultassi/2024/09/30/monsters-the-lyle-and-erik-menendez-story-dethroned-in-netflixs-top-10-list-by-a-new-show> [https://perma.cc/24W5-Q6EX] (further

into evidence multiple audio recordings from therapy sessions that the brothers conducted with their clinical psychologist, Dr. Leon Jerome Oziel.⁹ In response, the brothers argued that these audio recordings were protected from disclosure under California's psychotherapist-patient privilege.¹⁰ All fifty states have adopted a psychotherapist-patient privilege,¹¹ and the U.S. Supreme Court recognized the existence of the privilege federally in *Jaffee v. Redmond* in 1996.¹² This privilege protects from disclosure any confidential communications made between a patient and a mental health professional for the purposes of treatment.¹³ Since these sessions were held for the purpose of treatment, and the Menendez brothers never revealed this information to a third party, they argued that their discussions were fully protected by the privilege.¹⁴

However, prosecutors believed that in at least two of these recordings, the communications lost their protected nature

describing both the show's popularity, but also "relatively poor ratings from critics and audiences" and "massive pushback from the Menendez family").

⁹ Allan E. Barsky, *Exceptions to Privilege When Clients Threaten Their Therapist*, *PSYCHOLOGY TODAY* (Oct. 15, 2024), <https://www.psychologytoday.com/us/blog/agens-scientiam/202410/exceptions-to-privilege-when-clients-threaten-their-therapist> [<https://perma.cc/3BS2-G4SV>] ("Oziel recorded some of his notes from sessions with Erik on an audiocassette. He also recorded parts of actual sessions involving Erik and Lyle. . . . A key issue raised in the criminal trial was whether the tapes could be admitted into evidence . . .").

¹⁰ *Menendez v. Superior Ct.*, 834 P.2d 786, 789 (Cal. 1992) (noting further that "Dr. Oziel filed a motion in the Los Angeles Superior Court . . . effectively claiming for the Menendezes the psychotherapist-patient privilege," and that "[t]he Menendezes successfully moved to intervene").

¹¹ *Jaffee v. Redmond*, 518 U.S. 1, 12 (1996) ("That it is appropriate for the federal courts to recognize a psychotherapist privilege under Rule 501 is confirmed by the fact that all 50 States and the District of Columbia have enacted into law some form of psychotherapist privilege.").

¹² *Id.* at 15 (holding "that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence").

¹³ *Id.* (concluding that "[b]ecause we agree with the judgment of the state legislatures and the Advisory Committee that a psychotherapist-patient privilege will serve a 'public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth,' we hold that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence" (citation omitted) (quoting *Trammel v. United States*, 445 U.S. 40, 50 (1980))).

¹⁴ *Menendez*, 834 P.2d at 795 ("The Menendezes do not seriously argue against the applicability of the exception. Rather, they maintain that we should remand the matter to the superior court to make findings of fact under *Wharton*.").

because of the so-called “dangerous patient exception.”¹⁵ This exception generally holds that if a patient communicates to a psychotherapist a serious threat to do imminent harm, the communication may lose its protection under the privilege, and the psychotherapist may be able testify about the communication in a later criminal trial.¹⁶ According to prosecutors, at the time two of the recordings were made, the Menendez brothers had already threatened both Dr. Oziel and “also collaterally endangered his wife, Laurel Oziel, and his lover, Judalon Smyth, because of their relationships.”¹⁷ Because there was reason to believe that disclosure of these communications was necessary to prevent future serious harm, the court ultimately held that two of these recordings were covered by the dangerous patient exception, and therefore admissible into evidence.¹⁸

California is one of several jurisdictions to have adopted a dangerous patient exception.¹⁹ At the federal level, circuits are split on the question of whether there should be such an exception to the psychotherapist-patient privilege.²⁰ Commentators have been divided on the efficacy of this exception.²¹

¹⁵ The U.S. Supreme Court foreshadowed the possibility of this exception in a footnote in the original *Jaffee* opinion, stating,

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.

Jaffee, 518 U.S. at 18 n.19.

¹⁶ See *infra* subpart I.B and associated citations for a detailed discussion of the development and definition of this exception.

¹⁷ *Menendez*, 834 P.2d at 791.

¹⁸ *Id.* at 795 (“The ‘dangerous patient’ exception, however, was indeed applicable.”).

¹⁹ Deborah Paruch, *From Trusted Confidant to Witness for the Prosecution: The Case Against the Recognition of a Dangerous-Patient Exception to the Psychotherapist-Patient Privilege*, 9 U.N.H. L. REV. 327, 377 (2011) (explaining that “[t]here is similar disarray among the states with respect to the recognition of the dangerous-patient exception to the testimonial privilege” and then providing a summary of ways that states vary in their recognition and application of this exception).

²⁰ *Id.* at 352–61 (exploring how the Tenth, Sixth, Ninth, and Fifth Circuits have ruled on this issue with accompanying summaries of major cases from these circuits).

²¹ See, e.g., Catherine M. Baytion, Note, *Toward Uniform Application of a Federal Psychotherapist-Patient Privilege*, 70 WASH. L. REV. 153, 170 (1995) (“The dangerous patient exception to the psychotherapist-patient privilege furthers the policy of preventing imminent physical harm.”); George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The Tarasoff Duty and the Jaffee Footnote*, 74 WASH. L. REV. 33, 67 (1999) (ultimately concluding that the “[e]xception to the evidentiary privilege is justified for testimony in a restraining order proceeding or in a proceeding to hospitalize the patient,” but arguing that

Supporters of the exception claim that it is necessary to ensure public safety.²² Further, supporters of this exception point out that therapists already have a professional and civil obligation to violate confidentiality if a client communicates information that suggests an immediate and serious risk of physical harm to themselves or others. So, for example, if during a treatment session, the Menendez brothers communicated that they intended to murder their parents, Dr. Oziel would likely have a professional and civil obligation to violate confidentiality and take steps to notify law enforcement. The dangerous patient exception is not about this violation of confidentiality, but rather the question of whether such statements made by a client during a treatment session could be used as evidence in a future criminal trial. Thus, supporters of the dangerous patient exception would argue that, since patients are already generally notified of therapists' professional obligation to violate confidentiality in such high-risk circumstances, allowing evidence of such statements in future legal proceedings should not have any chilling effect on treatment.

However, critics of the exception, including the American Psychiatric Association (APA), argue that, particularly at the federal level, this exception does little to protect public safety, and may instead discourage patients from receiving life-saving treatment.²³ That is because, as adopted in some federal

"[n]o similar justification exists . . . for compelling a therapist to testify against her patient in a criminal proceeding after the threat of harm has been carried out or is no longer viable"); Daniel M. Buroker, Note, *The Psychotherapist-Patient Privilege and Post-Jaffee Confusion*, 89 IOWA L. REV. 1373, 1389 (2004) (claiming that "admitting an exception to the psychotherapist-patient privilege only in those cases where the psychotherapist's testimony will substantially advance the mental health interests of the patient would avoid confusion in this area of the law" thereby preserving "the ability of a psychotherapist to testify in proceedings where involuntary commitment of a patient who is dangerous to himself or others is necessary"); Paruch, *supra* note 19, at 393-405 (arguing for only limited usage of a dangerous patient exception and providing a more thorough proposal); Blake R. Hills, *The Cat Is Already out of the Bag: Resolving the Circuit Split over the Dangerous Patient Exception to the Psychotherapist-Patient Privilege*, 49 U. BALT. L. REV. 153, 181 (2020) (concluding that "the Supreme Court should resolve the split among the circuits by relying on the policy that the psychotherapist-patient privilege must only be used in a way that serves public ends. Doing so requires the recognition of the dangerous patient exception" (footnote omitted)).

²² Anthony Parsio, Note, *The Psychotherapist-Patient Privilege: The Perils of Recognizing a "Dangerous Patient" Exception in Criminal Trials*, 41 NEW ENG. L. REV. 623, 645 (2007) ("[T]he rationale for recognizing an exception is the health and safety of the potential victim.").

²³ ROBERT WEINSTOCK ET AL., AM. PSYCHIATRIC ASS'N., POSITION STATEMENT ON NO "DANGEROUS PATIENT" EXCEPTION TO FEDERAL PSYCHOTHERAPIST-PATIENT TESTIMONIAL PRIVILEGE 2 (2010) [<https://perma.cc/JT2N-27L2>] (providing an explanation of these

circuits, the exception is not limited to future danger but rather measured at the time the statement was made by the allegedly dangerous patient. So, for example, in the Menendez case, the incriminating statements made by the brothers during treatment would be admissible under the exception, if Dr. Oziel reasonably believed that the brothers posed a risk at the time of the statements. Even though that threat may have passed at the time of the Menendez brothers criminal murder trial, the exception still permitted the admission of the evidence to help prove their guilt. Thus, the APA argued that application of the exception is not really about the “prevention of future danger.”²⁴ Instead, the APA worried that “[s]ince patients’ openness in treatment can be a prerequisite to resolving the problems leading to potential violence, any impediment to such openness resulting from uncertainty as to whether a privilege exists would limit the ability of treatment to resolve such problems.”²⁵

Thus, the debate over the dangerous patient exception has largely boiled down to dueling theories about how patients would respond to different legal rules. Does the dangerous patient exception chill patients from receiving vital mental health treatment? And does this contribute to more harm in the form of violence against others or patient self-harm? To our knowledge, no prior study has provided an empirical answer to these questions. This question is of particular importance, because federal circuits have split on this issue.²⁶ Because of this circuit split and the importance of this issue in many criminal cases, commentators have predicted that the U.S. Supreme Court will likely step in to resolve this issue at some point in the future.²⁷

This Article takes advantage of the existing circuit split to test the effect of the dangerous patient exception on homicides and suicides. We find that jurisdictions that have recognized a dangerous patient exception have subsequently experienced a statistically significant increase in suicides. However, we find no evidence that the recognition of the dangerous patient exception is associated with any change in homicide rates. These results are consistent with predictions by critics, like

objections, and then concluding that “the problems and dangers created by a ‘dangerous patient’ exception to the federal psychotherapist-patient privilege outweigh any possible advantages”).

²⁴ *Id.*

²⁵ *Id.*

²⁶ See *infra* Part II.

²⁷ ROBERT WEINSTOCK ET AL., *supra* note 23, at 2 (“[I]t is likely that the US Supreme Court eventually will hear a case to resolve the conflict.”).

the American Psychiatric Association, that the recognition of a dangerous patient exception and changes in subsequent warnings provided to clients may unintentionally prevent clients from receiving adequate treatment. As more federal circuits, and potentially the U.S. Supreme Court, consider this issue in the future, this evidence should caution against the adoption of a dangerous patient exception to the psychotherapist-patient testimonial privilege.

This Article proceeds in five parts. Part I provides background on mental health treatment, crime, and the U.S. Supreme Court's recognition of the psychotherapist-patient privilege in *Jaffee v. Redmond*. It also distinguishes between confidentiality in mental health treatments and the application of an evidentiary privilege. Part II then chronicles the emerging circuit split over the application of a dangerous patient exception to the psychotherapist-patient privilege, including summaries of cases in the Fifth, Sixth, Eighth, Ninth, and Tenth Circuits that have reached different conclusions on how to interpret a critical footnote in *Jaffee* on the subject. Next, Part III explains the methodology and dataset used in this article. Part IV presents our central findings on the relationship between recognition of a dangerous patient exception and subsequent changes in homicide and suicide rates. Finally, Part V considers the implications of our findings for future case law on the appropriateness of the dangerous patient exception.

I

CRIME, MENTAL ILLNESS, AND THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

This Part provides background information on the link between mental illness, crime, and the development of the psychotherapist-patient privilege. Critics of the dangerous patient exception worry that, if courts recognize such an exception to the psychotherapist-patient privilege, therapists will be obligated to warn patients about the existence of this law. This, in turn, will chill patients from receiving mental health treatment that could help prevent harm to themselves or to others in the forms of suicide and crimes against others. Central to that critique is an assumption that some types of untreated mental illness may contribute to crime or self-harm. As will be discussed in Subpart A, we show that there is considerable evidence linking untreated mental illness to crime, even if most individuals who live with a mental illness at some point in their life never commit any crime. Having briefly summarized the literature on this underlying assumption, Subpart B describes

the U.S. Supreme Court's recognition of the psychotherapist-patient privilege in 1996 in *Jaffee v. Redmond*. In doing so, this subpart also distinguishes between confidentiality and evidentiary privilege. This sets the stage for the still-unresolved issue of whether the Court intended its holding in *Jaffee* to include a so-called dangerous patient exception.

A. The Relationship Between Crime and Mental Illness

For years, researchers have been exploring the potential link between mental illness and crimes, particularly violent crimes. The existing empirical evidence tends to show that, while certain types of mental health disorders, including bipolar disorder, schizophrenia, and antisocial personality disorder, can lead to a higher risk of violence, generally, a diagnosis with a mental health disorder does not make a person more likely to be violent.²⁸ However, there are some factors that can make the risk of becoming violent at some point in the future higher. Substance abuse is a major comorbid contributor to the potential for violence.²⁹ Some studies also find that environmental

²⁸ Richard A. Friedman, *Violence and Mental Illness—How Strong Is the Link?*, 355 NEW ENG. J. MED. 2064, 2065 (2006) (stating that “patients with serious mental illness—those with schizophrenia, major depression, or bipolar disorder—were two to three times as likely as people without such an illness to be assaultive” and further explaining that, “the lifetime prevalence of violence among people with serious mental illness was 16%, as compared with 7% among people without mental illness”); Fred E. Markowitz, *Mental Illness, Crime, and Violence: Risk, Context, and Social Control*, 16 AGGRESSION & VIOLENT BEHAV. 36, 40 (2011) (“Both the treatment sample and general population studies show that, in many cases, those experiencing certain ‘positive’ psychotic or ‘threat control/override’ symptoms (e.g., delusional thinking and hallucinations) are at an increased risk of violence.”); Paul G. Nestor, *Mental Disorder and Violence: Personality Dimensions and Clinical Features*, 159 AM. J. PSYCHIATRY 1973, 1974, 1977 (2002) (concluding that “[l]ongitudinal studies have provided strong evidence of personality disorders representing a significant clinical risk for violence,” and further explaining that “the findings of these studies have provided the strongest empirical evidence that the relationship between particular mental disorders and violence may be mediated by different configurations across these personality dimensions”); Ann Stueve & Bruce G. Link, *Violence and Psychiatric Disorders: Results from an Epidemiological Study of Young Adults in Israel*, 68 PSYCHIATRIC Q. 327, 327–30 (1997) (explaining the disagreement about the strength of the relationship between some types of mental illness and crime, while acknowledging the complication issue of comorbidities of mental illness with substance abuse).

²⁹ Stueve & Link, *supra* note 28, at 329 (“[T]he association between various diagnoses of mental illness and violence may be due solely to the comorbidity of substance abuse or antisocial personality disorder.” (citations omitted)); Nestor, *supra* note 28, at 1974 (“Substance abuse disorders represent by far the strongest correlates of violence among all mental disorders.”); Friedman, *supra* note 28, at 2065 (“ . . . substance abuse among the mentally ill compounds the increased risk of violence.”).

factors can increase the risk of violence, such as lower education levels or increased poverty.³⁰ One study even went so far as to suggest that social factors are a requirement for seeing severe mental health issues lead to violent behavior.³¹ And any discussion of the link between mental illness and crime must acknowledge the complicated history of deinstitutionalization in the United States. As mental institutions shut down during the second half of the twentieth century, those with mental illnesses became overrepresented within the criminal justice system.³² Most studies seem to conclude that mental health treatment may help prevent individuals from acting violently.³³ This means that if preventing violence is the desired outcome, at least one strategy to implement that would be increasing access to or the efficacy of treatment.

B. The Development of the Psychotherapist-Patient Privilege

In 1972, the Chief Justice of the United States Supreme Court transmitted to Congress proposed Rules of Evidence, which had been drafted by a Judicial Conference Advisory Committee and approved by the Judicial Conference of the United States and by the Court.³⁴ Initially, the proposed rules provided for nine specific testimonial privileges, including a psychotherapist-patient privilege.³⁵ However, Congress rejected this recommendation and substituted in its place a single rule, Federal Rule of Evidence (FRE) 501, which simply stated that

³⁰ Stueve & Link, *supra* note 28, at 340 (“The association between psychotic/bipolar disorders and assaultive behavior was stronger among individuals with less education.”); Virginia Aldigé Hiday, *The Social Context of Mental Illness and Violence*, 36 J. HEALTH & SOC. BEHAV. 122, 129 (1995) (“The model indicates that social disorganization and the accompanying poverty lead to victimization and violence.”).

³¹ Hiday, *supra* note 30, at 130 (stating that “for severe mental illness to lead to violence, social factors must intervene”).

³² Markowitz, *supra* note 28, at 40–41 (providing a summary of the effects of deinstitutionalization).

³³ Nestor, *supra* note 28, at 1977 (“[C]linical risk factors for violence might be identified as targets of potential treatment and prevention, especially important considering that most—if not all—violent mentally disordered subjects are seen in mainstream mental health settings, often long before becoming violent.” (citations omitted)); Markowitz, *supra* note 28, at 41–42 (describing how patient treatment may be a more successful alternative to criminal justice responses to crime by individuals living with a mental illness).

³⁴ *Jaffee v. Redmond*, 518 U.S. 1, 8 n.7 (1996).

³⁵ *Id.* at 14 (“The uniform judgment of the States is reinforced by the fact that a psychotherapist privilege was among the nine specific privileges recommended by the Advisory Committee in its proposed privilege rules.”).

“the common law as . . . interpreted by the courts of the United States in the light of reason and experience,” governs any claim of privilege.³⁶ Under this more open-ended approach, courts ask whether the claimed privilege promotes sufficiently important interests to outweigh the need for probative evidence.³⁷

Applying this test under FRE 501, the U.S. Supreme Court first recognized the psychotherapist-patient privilege in 1996 in *Jaffee v. Redmond*.³⁸ There, police officer Mary Lu Redmond shot and killed Ricky Allen in Hoffman Estates, Illinois.³⁹ The shooting occurred shortly after Redmond arrived at the scene to respond to a “fight in progress.”⁴⁰ When she arrived, she was greeted by two of Allen’s sisters who told her that there had been a stabbing in the apartment.⁴¹ Redmond claimed that several men ran out of the apartment building as she approached, including one carrying a pipe.⁴² She then pulled her revolver.⁴³ Thereafter, Redmond claimed that two other men came out of the apartment, including Allen, who she saw carrying a butcher knife.⁴⁴ After Allen allegedly ignored Redmond’s demand to drop the weapon, Redmond shot and killed Allen.⁴⁵ Thereafter, Redmond received extensive counseling from a clinical social worker.⁴⁶

³⁶ FED. R. EVID. 501, Pub. L. No. 93-595, 88 Stat. 1933 (1975) (amended 2011).

³⁷ See, e.g., *Trammel v. United States*, 445 U.S. 40, 51 (1980) (explaining the history of privilege after the passage of the Federal Rules of Evidence, and concluding that in deciding on the application of the spousal testimonial privilege, “we must decide whether the privilege against adverse spousal testimony promotes sufficiently important interests to outweigh the need for probative evidence in the administration of criminal justice”); *Jaffee*, 518 U.S. at 9–10 (citing this same line from *Trammel* to support this test).

³⁸ *Jaffee*, 518 U.S. at 9–10 (generally considering the federal application of the psychotherapist-patient privilege and explaining, “[g]uided by these principles, the question we address today is whether a privilege protecting confidential communications between a psychotherapist and her patient ‘promotes sufficiently important interests to outweigh the need for probative evidence’ (quoting *Trammel*, 445 U.S. at 51)).

³⁹ *Id.* at 4.

⁴⁰ *Id.* (describing further how Redmond alleged that “[a]s she arrived at the scene, two of Allen’s sisters ran toward her squad car, waving their arms and shouting”).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.* at 4–5 (further detailing how Redmond claimed that Allen “disregarded her repeated commands to drop the weapon” and that “Redmond shot Allen when she believed he was about to stab the man he was chasing”).

⁴⁶ *Id.* at 5.

Allen's estate filed suit under 42 U.S.C. § 1983 alleging that Redmond had violated Allen's Fourth Amendment rights through excessive and unjustified use of force.⁴⁷ His estate also filed claims under the Illinois wrongful death statute.⁴⁸ At trial, the Allen family recounted the events in question differently than Redmond, claiming that she drew her revolver before she exited her vehicle, and that Allen was unarmed when he exited the apartment.⁴⁹ When Allen's estate learned that Redmond had conducted around fifty counseling sessions with a clinical social worker, they sought access to the notes on these sessions.⁵⁰ Redmond and her therapist refused this request, arguing that the details on these conversations should be protected by the psychotherapist-patient privilege.⁵¹ The trial court rejected the application of the privilege, but Redmond and her therapist still refused to turn over notes from these sessions.⁵² Thus, before the jury issued a verdict, the trial court instructed the jury that they "could therefore presume that the contents of the notes would have been unfavorable" to Redmond.⁵³ The jury then awarded Allen's estate \$45,000 on the federal claim and \$500,000 on the state claim.⁵⁴ The Seventh Circuit reversed and remanded the matter for a new trial after recognizing the existence of a psychotherapist-patient privilege.⁵⁵ Allen's estate appealed this Seventh Circuit decision thereafter to the U.S. Supreme Court.⁵⁶

⁴⁷ *Id.*; see also 42 U.S.C. § 1983 (providing individuals with a civil right of action against state and local government officials that engages in a "deprivation of any rights, privileges, or immunities secured by the Constitution and laws"); U.S. CONST. amend. IV (prohibiting "unreasonable searches and seizures").

⁴⁸ *Jaffee*, 518 U.S. at 5; see also 740 ILL. COMP. STAT. 180/1 (1994) (allowing the recovery of damages "[w]henver the death of a person shall be caused by wrongful act, neglect or default").

⁴⁹ *Jaffee*, 518 U.S. at 5.

⁵⁰ *Id.* (noting further that the clinical social worker, named Karen Beyer, was licensed in the State of Illinois to provide this kind of therapy).

⁵¹ *Id.* ("Respondents . . . asserted that the contents of the conversations between Beyer and Redmond were protected against involuntary disclosure by a psychotherapist-patient privilege.").

⁵² *Id.* (stating that "[n]either Beyer nor Redmond, however, complied with [the court's] order to disclose the contents of Beyer's notes").

⁵³ *Id.* at 5-6.

⁵⁴ *Id.* at 6.

⁵⁵ *Jaffee v. Redmond*, 51 F.3d 1346, 1355-58 (7th Cir. 1995) ("Reason tells us that psychotherapists and patients share a unique relationship, in which the patient's ability to communicate freely without the fear of public disclosure is the key to successful treatment.").

⁵⁶ *Jaffee*, 518 U.S. at 7-8.

Before the Court heard *Jaffee*, the circuits were split on the recognition of the psychotherapist-patient privilege.⁵⁷ By a seven-to-two margin, the Court in *Jaffee* affirmed the Seventh Circuit and recognized a federal psychotherapist-patient privilege.⁵⁸ In conducting the “reason and experience” inquiry required by Rule 501, the Court first considered the private interests at stake, concluding that patients’ interest in the proposed privilege is quite high.⁵⁹ The Court compared the treatment of physical ailments to that of mental illness, explaining:

Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.⁶⁰

Next, the Court considered the public’s interest in the privilege, judging it to be high as well. As the Court put it, “[t]he psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem,” and in the Court’s opinion, “[t]he mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”⁶¹

The Court reinforced its conclusions about the value of the privilege by looking to the “experience” of the states and the substance of the proposed federal rules.⁶² Surveying the states, the Court noted that all fifty states and the District of Columbia provide for a psychotherapist-patient privilege.⁶³ As the Court

⁵⁷ *Id.* at 7 (“The United States Courts of Appeals do not uniformly agree that the federal courts should recognize a psychotherapist privilege under Rule 501.”).

⁵⁸ *Id.* at 2–3 (noting Stevens, joined by O’Connor, Kennedy, Souter, Thomas, Ginsburg, and Breyer, J.J., in the majority; Scalia, J., filed a dissenting opinion, joined by Rehnquist, C.J.).

⁵⁹ *Id.* at 15 (explaining this reasoning and holding “that confidential communications between a licensed psychotherapist and her patients in the course of diagnosis or treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence”).

⁶⁰ *Id.* at 10.

⁶¹ *Id.* at 11.

⁶² *Id.* at 12–13.

⁶³ *Id.* at 12.

noted, “any State’s promise of confidentiality would have little value if the patient were aware that the privilege would not be honored in federal court.”⁶⁴ Further, proposed Rule 504 would have provided a federal psychotherapist-patient privilege, and the commentary to Rule 501 expressly allowed for the possibility.⁶⁵ The position taken by the proposed rules thus favored a recognition of the privilege.⁶⁶

On the other side of the balance, the Court judged the probative value of the evidence that would be lost to the privilege to be “modest”:

If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without a privilege, much of the desirable evidence to which litigants such as petitioner seek access . . . is unlikely to come into being. This unspoken “evidence” will therefore serve no greater truth-seeking function than if it had been spoken and privileged.⁶⁷

Given this balance, the Court recognized a federal privilege over a patient’s communications whenever the communications (1) were made to a licensed psychotherapist or social worker, (2) were confidential, and (3) were made for diagnosis or treatment.⁶⁸

1. *The Importance of Confidentiality and Privilege*

Mental health professionals have been considering the impact of confidentiality and privilege laws for years.⁶⁹ Much of the research is done by collecting surveys both from

⁶⁴ *Id.* at 13.

⁶⁵ *Id.* at 14–15.

⁶⁶ *Id.* at 15.

⁶⁷ *Id.* at 11–12.

⁶⁸ *Id.* at 16–18.

⁶⁹ See generally Jane L. Givens & Jennifer Tija, *Depressed Medical Students’ Use of Mental Health Services and Barriers to Use*, 77 ACAD. MED. 918 (2002) (conducting a study of depression among medical students and finding that lack of confidentiality was a barrier in around 37% of cases); Harriett L. Glossoff et al., *Privileged Communication in the Psychologist-Client Relationship*, 28 PRO. PSYCH. RSCH. & PRAC. 573 (1997) (analyzing state laws on privileged communications between mental health professionals and patients); Ryan D. Jagim, William D. Wittman & John O. Noll, *Mental Health Professionals’ Attitudes Towards Confidentiality, Privilege, and Third-Party Disclosure*, 9 PROF. PSYCH. 458 (1978) (providing the results of a survey of sixty-four health professionals in North Dakota); Michele Smith-Bell & William J. Winslade, *Privacy, Confidentiality, and Privilege*

professionals within these industries and clients (or potential clients) to gain insight into the opinions, beliefs, and general knowledge of those individuals. For example, one study looking at why medical students were not utilizing mental health services on campus, found that more than a third of respondents cited concerns about a lack of confidentiality.⁷⁰ How these results would translate to people with less knowledge of the healthcare system than medical students is unclear; however, what is clear, is that mental health professionals believe that there would be a decrease in services sought if there was any amount of degradation to the therapist-patient relationship, either by exemptions to confidentiality or privilege.⁷¹

These studies also looked at the understanding and expansion of privilege in the law. When asked about current privilege laws, most mental health professionals were unable to accurately recognize which ones they fell under, but they supported the idea that therapists (as well physicians and psychiatrists) should be subject to privilege protections.⁷² Other papers noted the legal trend to expand privilege to include mental health professionals, while expressing concerns that granting exceptions to privilege could cause patients to not seek help⁷³ and could potentially be considered infringement on personal privacy rights.

2. Confidentiality Distinguished from Privilege

Importantly, the scope of a therapist's duty of confidentiality is different from the scope of the psychotherapist-patient privilege. "Confidentiality" refers to the "broad blanket"

in *Psychotherapeutic Relationships*, 64 AM. J. ORTHOPSYCHIATRY 180 (1994) (considering the challenges mental health professionals face in breaking confidentiality).

⁷⁰ Givens & Tjia, *supra* note 69 (finding that about 37% of respondents reported that lack of confidentiality was a barrier to treatment).

⁷¹ See, e.g., Glossoff et al, *supra* note 69, at 573; Jagim, Wittman & Noll, *supra* note 69, at 463.

⁷² Jagim, Wittman & Noll, *supra* note 69. *But cf.* Elizabeth Henderson, *Potentially Dangerous Patients: A Review of the Duty to Warn*, 41 J. EMERGENCY NURSING 193, 194–97 (2015) (finding a fairly broad awareness of these obligations via a meta-analysis of existing studies).

⁷³ Paul S. Appelbaum, *Privilege in the Federal Courts: Should There Be a "Dangerous Patient Exception"?*, 59 PSYCH. SERVS. 714, 715–16 (2008) (explaining that, "[e]ven if the dangerous patient exception were narrowly construed, it would inhibit help seeking by the very people in whose treatment society has the strongest interest—those who have harmed or are likely to harm others").

of privacy that state law places over the therapist-patient relationship.⁷⁴ “Privilege” refers to the right of the patient to prevent the psychotherapist from testifying in court⁷⁵ or to resist the discovery of privileged material.⁷⁶ Conclusions about the law of confidentiality do not necessarily lead to like conclusions about the law of privilege, as the two doctrines are analytically distinct.⁷⁷ However, the operation of state confidentiality laws may have important effects on the operation of the federal privilege.⁷⁸

As a matter of tort liability in state court, *Tarasoff v. Regents of the University of California* helped establish a national norm of mental health professionals providing notices to clients about the limits of confidentiality during treatment.⁷⁹ In that case, Prosenjit Poddar allegedly killed Tatiana Tarasoff two months after Poddar told his psychologist, Dr. Lawrence Moore, about his intention to commit the homicide.⁸⁰ When Dr. Moore notified Dr. Harvey Powelson, his supervisor at the time, Dr. Powelson allegedly directed Dr. Moore to take no further action.⁸¹ Moore and Powelson failed to notify Tarasoff of the risk she faced from Poddar.⁸² Moore, Powelson, and their employer (the University of California) attempted to avoid tort liability for Tarasoff’s death by arguing that, since she was not their patient, they had no obligation to warn her of this possible risk.⁸³

The California Supreme Court disagreed. It held that, in terms of the application of tort liability, “[w]hen 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

⁷⁴ *United States v. Chase*, 340 F.3d 978, 982 (9th Cir. 2003) (“[C]onfidentiality,’ . . . refer[s] to the broad blanket of privacy that state laws place over the psychotherapist-patient relationship.”).

⁷⁵ *Id.* (“By ‘privilege,’ we mean the specific right of a patient to prevent the psychotherapist from testifying in court.”).

⁷⁶ *Jaffee v. Redmond*, 518 U.S. 1, 9 (1996) (describing the use of the privilege of block discovery of notes from confidential therapy sessions).

⁷⁷ *Chase*, 340 F.3d at 982 (stating that these are “two distinct concepts”).

⁷⁸ *United States v. Auster*, 517 F.3d 312, 317 (5th Cir. 2008) (“Federal law does not depend on state law but instead is turning on the lack of confidentiality, regardless of the reason. Though, in certain instances, state law may play a role in negating confidentiality . . .”).

⁷⁹ 551 P.2d 334 (Cal. 1976).

⁸⁰ *Id.* at 339.

⁸¹ *Id.* at 339–40.

⁸² *Id.* at 340.

⁸³ *Id.*

to protect the intended victim against such danger.”⁸⁴ Following *Tarasoff*, almost all states have established laws requiring mental health professionals to provide some sort of *Tarasoff* warning to patients, with variation as to the scope of the exception to the normal rule of confidentiality and whether warnings are mandatory or permissive.⁸⁵ Additionally, psychotherapists abide by ethical rules that require the therapist to maintain confidentiality and advise patients of the limits of confidentiality.⁸⁶ Those rules would require a limits-of-confidentiality explanation at the outset of the therapist-patient relationship.⁸⁷ There is some variation as to the timing and content of therapists’ discussion of their *Tarasoff* duties with patients in actual practice.⁸⁸

Thus, an array of privilege and confidentiality standards apply to mental health professionals across the United States. Mental health professionals typically provide patients with guarantees of confidentiality during treatment, which can be vital for effective treatment. However, providers have a civil and professional obligation to break confidentiality if a patient poses a serious risk to themselves or others. All states also recognize an evidentiary privilege that prevents the admission of evidence into courts from confidential communications made during treatment sessions. The U.S. Supreme Court similarly recognized such a federal evidentiary privilege in *Jaffee*. However, there exists considerable legal variation across the

⁸⁴ *Id.*

⁸⁵ Griffin Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of Tarasoff v. Regents on Homicidal Activity*, 57 J.L. & ECON. 321, 324–25 (2014) (finding that “almost all states took a stand with respect to third-party duty in response to the *Tarasoff* ruling, [but] not all states hold therapists to the same standard,” and providing a detailed breakdown of state variation in Table 1).

⁸⁶ AM. PSYCH. ASS’N, ETHICAL PRINCIPLES OF PSYCHOLOGISTS AND CODE OF CONDUCT 7–8 (2002), <https://www.apa.org/ethics/code/ethics-code-2017.pdf> [<https://perma.cc/EUV8-8YED>] (providing the principles of ethics among a major psychological association).

⁸⁷ *Id.* at 7 (“Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities.”).

⁸⁸ Elisa Klinka, Note, *It’s Been a Privilege: Advising Patients of the Tarasoff Duty and Its Legal Consequences for the Federal Psychotherapist-Patient Privilege*, 78 FORDHAM L. REV. 863, 891–93 (2009) (explaining that while “[s]ome psychotherapists inform patients in advance by advising patients about the limits of confidentiality and what matters may warrant disclosure to third parties” there is some variation in practice, including variation in how it is communicated substantively).

country in whether jurisdictions allow for a dangerous patient exception to this evidentiary privilege. As explained in the next Part, we use this variation as an opportunity to conduct the first empirical study of its kind on the effect of the dangerous patient exception.

II

THE CIRCUIT SPLIT ON THE DANGEROUS PATIENT EXCEPTION

In a footnote toward the end of its opinion in *Jaffee*, the Court wrote,

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.⁸⁹

Federal circuits have divided on how to handle this dicta.

This Part details the circuit split on the recognition of a dangerous patient exception. The Tenth Circuit has recognized an explicit exception to the privilege.⁹⁰ The Sixth, Eighth, and Ninth Circuits have chosen not to extend the exception.⁹¹ And the Fifth Circuit has held that patients who have received a limits-of-confidentiality explanation have no privilege in the first place.⁹² While these cases reach varying conclusions on this issue, they all spend some considerable time debating how the recognition of such an exception may impact patients, their willingness to seek care, and public safety. Thus, we argue, this study provides valuable insight into an unanswered empirical question that is driving a federal circuit split, likely to be decided by the U.S. Supreme Court in the future.

A. The Tenth Circuit: An Exception to the Privilege

The first federal appellate court to decide this question was the Tenth Circuit, in *United States v. Glass*.⁹³ In *Glass*, the defendant made threatening statements about President William Clinton and First Lady Hillary Clinton during treatment with

⁸⁹ *Jaffee v. Redmond*, 518 U.S. 1, 18 n.19 (1996).

⁹⁰ See *infra* subpart II.A and accompanying text.

⁹¹ See *infra* subpart II.B and accompanying text.

⁹² See *infra* subpart II.C and accompanying text.

⁹³ *United States v. Glass*, 133 F.3d 1356 (10th Cir. 1998).

his therapist.⁹⁴ Glass told his therapist that “he wanted to get in the history books” like prior attempted presidential assassins.⁹⁵ An outpatient nurse notified law enforcement of this threat after Glass left the hospital, leading to his indictment for “knowingly and willfully threatening to kill the President of the United States in violation of 18 U.S.C. § 871(a).”⁹⁶ Glass attempted to exclude any statements he made during a confidential therapy session under the psychotherapist-patient privilege.⁹⁷ The government argued that the psychotherapist-patient privilege should not apply in criminal cases at all.⁹⁸ The government believed that the original justifications for the existence of the psychotherapist-patient privilege, as recognized in *Jaffee*, should not apply to the “criminal setting” at all.⁹⁹ In response, Glass argued that, if footnote nineteen should be read as recognizing the existence of dangerous-patient exception to the privilege, it should apply only if the therapist’s disclosure is the lone means of averting a serious threat of harm.¹⁰⁰ Thus, neither party took the position that the privilege should apply without exception.

Reviewing *Jaffee* and its footnote, the court noted that the defendant’s statements were confidential and rejected the government’s argument that the privilege never applies in the criminal context.¹⁰¹ The court carefully broke down its mandate under FRE 501 and the limited guidance provided by the *Jaffee* majority.¹⁰² The Tenth Circuit explained that the

⁹⁴ *Id.* at 1357.

⁹⁵ *Id.* (mentioning specifically his desire to commit an act “like Hinkley [sic]” in apparent reference to the attempted assassination of President Ronald Reagan by John Hinckley Jr.).

⁹⁶ *Id.* This was ten days after Glass began outpatient care and was supposed to be at his father’s home, but had seemingly left without explanation, increasing the sense of urgency to act on the part of the mental health professional. *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.* (further explaining that, in doing so, the government asked the court to extend the Tenth Circuit’s prior case, citing *United States v. Burtrum*, 17 F.3d 1299 (10th Cir. 1994)).

¹⁰⁰ *Id.* at 1358 (“Because there was no evidentiary hearing or other fact-finding in this case to establish the patient knew what he was saying or to determine whether the threat of harm could only be averted by disclosure, Mr. Glass insists our embracing the government’s suggestion conflicts with *Jaffee*’s express reluctance to define the parameters of the privilege, preferring analysis on a case-by-case basis.”).

¹⁰¹ *Id.* at 1359 (considering the government argument and concluding that, “[c]ontrary to the government’s suggestion, we cannot fill that gap with our decision [in a prior case]”).

¹⁰² *Id.* (also providing a breakdown of the exact language in footnote nineteen).

psychotherapist-patient privilege, as a general matter, “serves the public interest by facilitating the provision of appropriate treatment for individuals suffering from the effects of a mental or emotional problem.”¹⁰³ They then emphasized that the privilege is “not rooted in any constitutional right of privacy but in a public good which overrides the quest for relevant evidence.”¹⁰⁴ Without considering the possibility that no exception should apply at all, the court remanded to the trial court to determine “whether . . . the threat was serious when it was uttered and whether its disclosure was the only means of averting harm to the President when the disclosure was made.”¹⁰⁵ The court in *Glass* therefore largely adopted the *Jaffee*’s dicta from footnote nineteen as the law and recognized the existence of a dangerous patient exception to the psychotherapist-patient privilege.

B. The Sixth, Eighth, and Ninth Circuits: No Exception

After *Glass*, three federal appellate circuits held that no dangerous-patient exception should be recognized. First, the Sixth rejected the existence of such an exception to the psychotherapist-patient privilege in *United States v. Hayes* in 2000.¹⁰⁶ That case originated from charges against postal service employee Roy Lee Hayes under 18 U.S.C. § 115(a)(1) for homicidal threats against his supervisor, Veda Odle.¹⁰⁷ During treatment sessions, Hayes allegedly told a therapist of his plan to murder Odle and “described in some detail how he would do so.”¹⁰⁸ Hayes filed a motion to dismiss his indictment under this statute and suppress both his mental health records and any testimony from his therapists under the

¹⁰³ *Id.* at 1358 (quoting *Jaffee v. Redmond*, 518 U.S. 1, 11 (1996)).

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 1360 (further stating that, “on remand, the district court must proceed under Fed. R. Evid. 104(a) to determine whether, in the context of this case, the threat was serious when it was uttered and whether its disclosure was the only means of averting harm to the President when the disclosure was made”).

¹⁰⁶ *United States v. Hayes*, 227 F.3d 578 (6th Cir. 2000).

¹⁰⁷ *Id.* at 579–80. The facts of the case are a bit complicated to fully reproduce but involve a defendant who had worked at the Postal Service his entire adult life prior to his gradual mental decline and subsequent treatment.

¹⁰⁸ *Id.* at 580 (further explaining that “Hayes claimed he could resist only because he ‘recognized’ that such action could jeopardize his continued employment.”).

psychotherapist-patient privilege.¹⁰⁹ Applying *Jaffee's* methodology, the court wrote:

While early advice to the patient that, in the event of the disclosure of a serious threat of harm to an identifiable victim, the therapist will have a duty to protect the intended victim, may have a marginal effect on a patient's candor in therapy sessions, an additional warning that the patient's statements may be used against him in a subsequent criminal prosecution would certainly chill and very likely terminate open dialogue. . . . Thus, if our Nation's mental health is indeed as valuable as the Supreme Court has indicated, and we think it is, the chilling effect that would result from the recognition of a "dangerous patient" exception and its logical consequences is the first reason to reject it.¹¹⁰

The court further reasoned that, while a therapist may be permitted to testify at an involuntary commitment proceeding to hospitalize the patient, if the therapist's testimony were to be used to imprison the patient, the patient would be highly unlikely to seek further treatment.¹¹¹ According to *Hayes*, while both involuntary hospitalization and criminal prosecution may serve to neutralize the threat posed by the patient, when it comes to prosecution, "the price paid in achieving that neutralization may often be that many patients will not seek the professional help they need to regain their mental and emotional health."¹¹² Thus, the rationale in *Hayes* and similar cases turns on the courts' assessment of the likely marginal effect on patients of permitting a breach of confidentiality only, versus permitting a breach of both confidentiality and the federal privilege.¹¹³

Second, in 2003, the Ninth Circuit in *United States v. Chase* similarly declined to recognize a dangerous patient exception.¹¹⁴ Steven Chase sought treatment after he began experiencing irritability, depression, and bouts of anger.¹¹⁵ Soon thereafter, Chase was diagnosed with bipolar type II disorder

¹⁰⁹ *Id.* at 581.

¹¹⁰ *Id.* at 584–85.

¹¹¹ *Id.* at 585.

¹¹² *Id.*

¹¹³ *Id.* at 586 ("Conversely, compliance with the professional duty to protect does not imply a duty to testify against a patient in criminal proceedings or in civil proceedings other than directly related to the patient's involuntary hospitalization, and such testimony is privileged and inadmissible [sic] if a patient properly asserts the psychotherapist/patient privilege.").

¹¹⁴ *United States v. Chase*, 340 F.3d 978, 979 (9th Cir. 2003).

¹¹⁵ *Id.*

and placed on medication to control his psychological symptoms.¹¹⁶ Chase attended psychotherapy sessions with Dr. Kay Dieter, a licensed psychiatrist at Kaiser Permanente.¹¹⁷ During one of these sessions, Chase showed Dr. Dieter a list of names, addresses, and social security numbers, which included two Federal Bureau of Investigations (FBI) agents.¹¹⁸ Chase told Dr. Dieter that he had thought about injuring or killing these individuals.¹¹⁹

Chase ultimately decided to disclose these threats to the local police department, who contacted the FBI.¹²⁰ Eventually, law enforcement arrested and charged Chase for the threats and unlawful possession of a weapon.¹²¹ Chase attempted to suppress the evidence of statements he allegedly made during therapy sessions by arguing that they were covered by the psychotherapist-patient privilege.¹²² The trial court rejected this argument by Chase, holding that the psychotherapist-patient privilege simply did not apply to these kinds of situations involving risks of imminent harm, where disclosure was the only method to avoid harm.¹²³ The Ninth Circuit reversed the lower court's ruling, holding that the psychotherapist-patient privilege covered even threatening statements made by patients during therapy sessions, and that no dangerous patient exception ought to exist under this privilege.¹²⁴

To begin with, the court rejected the government's argument that Chase's statements lost their confidential and privileged nature because they were threatening in nature.¹²⁵ Dr. Dieter also abided by her professional obligation to disclose this threat, as explained to Chase in the *Tarasoff* warning

¹¹⁶ *Id.* (adding further that the defendant would have meetings with Dr. Kay Dieter every few months).

¹¹⁷ *Id.* (also noting that the “[d]efendant met more often (ranging from bi-weekly to monthly) with psychologist Robert Schiff for psychotherapy”).

¹¹⁸ *Id.*

¹¹⁹ *Id.* (further explaining that upon hearing these threats, “Dr. Dieter warned Defendant that if he told her specifics about whom he planned to kill, she would have a duty to disclose the threats to the intended victims so that they could protect themselves”).

¹²⁰ *Id.* at 980.

¹²¹ *Id.* at 981 (noting that these charges were for threatening federal law enforcement officers and also noting that the possession of weapons charge was dismissed before trial).

¹²² *Id.* (explaining the trial court's rejection of this claim).

¹²³ *Id.*

¹²⁴ *Id.* at 981–82.

¹²⁵ *Id.* at 982.

she provided before their sessions, consistent with professional standards and state law.¹²⁶ But, as the court explained, this requirement had to do with the boundaries of “psychotherapist-patient *confidentiality*,” not “federal *testimonial privilege*.”¹²⁷

On the latter, the court declined to recognize a dangerous patient exception on several grounds. The court worried that extending a dangerous patient exception federally, when it is often not recognized at the state level, would weaken the protections afforded by such parallel state rules of evidence.¹²⁸ Congress included no such exception in its proposed Federal Rule of Evidence 504 in 1972.¹²⁹ And, perhaps most relevant to the scope of this Article, the court worried that “[a]ny exception necessarily has some adverse effect on the candor that the psychotherapist-patient privilege is meant to encourage, because patients will be more reluctant to divulge unsavory thoughts or urges if they know that the therapist may be required to testify about the content of therapeutic sessions.”¹³⁰ In particular, given that an exception to the testimonial privilege would primarily have punitive rather than just protective purposes, the court worried it would have particularly harmful effects on the psychotherapist-patient relationship.¹³¹ Thus, the Ninth Circuit was concerned, like the Sixth Circuit, about how a dangerous patient exception would have a “chilling effect” on the willingness of patients to get vital mental health treatment.¹³²

Third, in *United States v. Ghane*, the Eighth Circuit similarly rejected the dangerous patient exception in 2012.¹³³ There, a federal jury convicted Dr. Hessam Ghane of possession of a chemical weapon (potassium cyanide).¹³⁴ The case reached the

¹²⁶ *Id.* at 984–85 (providing a summary of *Tarasoff* duties and warnings that are generally provided before sessions and discussing Oregon law).

¹²⁷ *Id.* at 985.

¹²⁸ *Id.* at 985–86 (also explaining that “[o]f the states in the Ninth Circuit, only California has an *evidentiary* dangerous-patient exception”).

¹²⁹ *Id.* at 989–90 (summarizing the legislative history of prior drafts of the Federal Rules of Evidence on privileges and discussing their prior use as persuasive guidance in interpreting the now admittedly broadly constructed FRE 501).

¹³⁰ *Id.* at 990.

¹³¹ *Id.* (“But we think that a patient will retain significantly greater residual trust when the therapist can disclose only for protective, rather than punitive, purposes. In other words, the marginal additional harm to the relationship is significant.”).

¹³² *Id.* at 990–91 (quoting *United States v. Hayes*, 227 F.3d 578, 584–85 (6th Cir. 2000)).

¹³³ *United States v. Ghane*, 673 F.3d 771 (8th Cir. 2012).

¹³⁴ *Id.* at 775.

Eighth Circuit after Ghane appealed his conviction, arguing that the trial court should have excluded evidence of comments that Ghane made to his mental health care provider as part of his treatment, as they were covered by the psychotherapist-patient privilege.¹³⁵ Ghane further cited *Hayes* and *Chase* in urging the Eighth Circuit to follow the holdings of its sister circuits in rejecting a dangerous patient exception.¹³⁶ The Eighth Circuit agreed.¹³⁷ Again, of particular note for the scope of this study, the Eighth Circuit echoed the Sixth and Ninth Circuits in arguing that the recognition of a dangerous patient exception would “have a deleterious effect on the ‘confidence and trust’ the Supreme Court held is implicit in the confidential relationship between the therapist and a patient.”¹³⁸ This could, in turn, reduce the willingness of a patient to get vital mental health treatment.¹³⁹

C. The Fifth Circuit: No Privilege

Finally, the Fifth Circuit in *United States v. Auster* took a somewhat different path than other circuits.¹⁴⁰ It held that, at least when the therapist has notified the patient of the therapist’s *Tarasoff* duty, a patient has no privilege because any threatening communication that follows would not be made confidentially.¹⁴¹

John Auster was a retired New Orleans police officer who had been receiving workers’ compensation.¹⁴² During sessions with his therapist, Auster allegedly made threats to carry out “violent retribution” if these workers’ compensation payments ended.¹⁴³ Auster had received *Tarasoff* warnings, which told him of his therapist’s “duty to warn” if he made comments that

¹³⁵ *Id.* at 779.

¹³⁶ *Id.* at 785.

¹³⁷ *Id.* (“We agree with our sister circuits that have rejected this exception and decline to interpret the dictum in *Jaffee* as establishing a precedentially binding ‘dangerous patient’ exception to the federal psychotherapist-patient testimonial privilege.”).

¹³⁸ *Id.*

¹³⁹ *Id.* at 785–86.

¹⁴⁰ *United States v. Auster*, 517 F.3d 312, 317 (5th Cir. 2008).

¹⁴¹ *Id.* at 321 (“Because Auster’s non-confidential statement cannot, as a matter of law, be privileged, we need not address whether the district court improperly suppressed evidence *sua sponte*, erroneously placed the burden of disproving the privilege on the government, or abused its discretion in failing to hold an evidentiary hearing.”).

¹⁴² *Id.* at 313.

¹⁴³ *Id.* at 314.

demonstrated an immediate danger to himself or others.¹⁴⁴ According to the court, a patient like Auster who has been told that the therapist will disclose threatening statements to third parties no longer has a reasonable expectation of confidentiality in threatening statements.¹⁴⁵ Other courts have identified this theory as one of “constructive waiver.”¹⁴⁶ In coming to this conclusion, that court expressly declined to decide whether a dangerous patient exception should be recognized for statements that are properly confidential and threatening, a situation that could arise when the therapist has failed to inform the patient of the *Tarasoff* duty.¹⁴⁷

Like other courts, *Auster* based its holding in large part on its assessment of the marginal costs and benefits of privileging threatening statements.¹⁴⁸ In *Auster*'s view, “the slight marginal benefit on effective therapy achieved by recognizing the privilege’s applicability where a patient already knows a threat will be conveyed is substantially outweighed by the marginal costs [to the criminal trial’s truth-seeking function].”¹⁴⁹ The court dismissed the Sixth and Ninth Circuits’ beliefs about the distinction patients may make between involuntary hospitalization and imprisonment, arguing that “the nuance—in terms of trust and confidence—likely does not matter much to the fellow committed.”¹⁵⁰ Because in the vast majority of cases the therapist will have advised the patient of the *Tarasoff* duty (whether at the outset of the therapy or as the conversation began to become threatening), *Auster* provides a *de facto*

¹⁴⁴ *Id.* at 313–14.

¹⁴⁵ *Id.* at 315 (“*Jaffee*’s explicit confidentiality requirement is fatal to Auster’s claim of privilege. Because Auster knew, when he made the September 13 threat, that it would be forwarded to CCMSI, his privilege claim fails, because he had no reasonable basis to conclude that the statement was confidential.”).

¹⁴⁶ *See, e.g.*, *United States v. Hayes*, 227 F.3d 578, 586 (6th Cir. 2000) (“Consequently, it is the government’s theory that, when Hayes chose to continue discussions with the therapists after receiving such advice, he *constructively waived* the protections of the psychotherapist/patient evidentiary privilege” (emphasis added)).

¹⁴⁷ *Auster*, 517 F.3d at 315 n.5 (“Although we decline to rule on whether there is a dangerous-patient exception to the psychotherapist-patient privilege, we note that the foregoing footnote demonstrates that the Court viewed the privilege as limited in scope.”).

¹⁴⁸ *Id.* at 317–18 (“[T]his cost-benefit calculation is inapt where the patient already knows the confidence will not be kept. Consider the marginal impact on effective therapy of allowing a statement into evidence that the patient knew would be communicated to third parties when he uttered it.”).

¹⁴⁹ *Id.* at 319 n.24.

¹⁵⁰ *Id.* at 319.

dangerous patient exception in the Fifth Circuit, without adopting a *de jure* exception in the way *Glass* did.

Thus, the “critical question” in the controversy surrounding the application of the privilege to threatening statements is the marginal cost to patients’ trust and confidence in denying the privilege, as measured by the number of patients who would become unwilling to continue treatment after learning about the dangerous patient exception, even if they had previously known of the therapist’s *Tarasoff* duty.¹⁵¹ The marginal costs to the federal courts’ truth-seeking function are similarly tied up in the question of whether some number of patients would be chilled from treatment without the privilege, given that their threatening communications may never come into being if they are chilled from speaking.¹⁵² Courts so far have been left to theorize or speculate as to how patients would act under these various approaches to the dangerous patient exception. We seek to provide an empirical answer to how patients have reacted to these alternative various legal rules.

III

DATA AND METHODOLOGY

This Article uses the variation in federal circuit recognition of the dangerous patient exception to the psychotherapist-patient privilege as an opportunity to test empirically the exception’s effect on patient outcomes and public safety. The subparts that follow describe this study’s data and methodology.

A. Data

Several prior studies have used variation in laws over time, particularly circuit splits at the federal level, to test the effect of a law on different outcome variables.¹⁵³ We use the

¹⁵¹ *Id.* at 318 n.18. Note, as well, how the court in *Auster* engaged with this question of whether the recognition of a dangerous patient exception will chill communication between a therapist and patient, thereby reducing the willingness of patients to get treatment.

¹⁵² *Id.* (“And for sincere threats, the target can now defend himself. If the therapist’s professional duty to thwart the patient’s plans has not already chilled the patient’s willingness to speak candidly, it is doubtful that the possibility that the therapist might also testify in federal court will do so.”).

¹⁵³ For example, prior studies on patent and copyright infringements have frequently used circuit court variation as an opportunity for empirical evaluation. Samantha M. Basso, Note, *When National Law Means Regional Law: A Look at the Non-Uniformity of Copyright Law and How the Federal Circuit Can Help*, 21 FED. CIR. B.J. 355, 355–59 (2012) (explaining how differences in circuit decisions in copyright law contributed to different legal regimes); Glynn S. Lunney Jr.,

variation between federal circuit courts to explore the effect of psychotherapist-patient privilege exceptions on homicides and suicides.¹⁵⁴

For this study's outcome variable, we use data from the Web-based Injury Statistics Query and Reporting System (WISQARS) provided by the Centers for Disease Control (CDC).¹⁵⁵ WISQARS is generally considered to be one of the most reliable measures of homicides and suicides, because the

Patent Law, the Federal Circuit, and the Supreme Court: A Quiet Revolution, 11 SUP. CT. ECON. REV. 1, 3 (2004) (similarly explaining the consequences of previous federal circuit variation on patent law by stating that before the creation of a single federal circuit to handle these matters, “[w]here traditionally, the doctrine of equivalents would reach most competing variations of a patented invention, under the Federal Circuit’s interpretation, even directly competing substitutes will often prove noninfringing”). Admittedly, there is some variation in how circuits handle cases. Whether, and in what amounts, they will hear oral arguments, write dispositions, or give unpublished opinions varies widely across the courts. Marin K. Levy, *The Mechanics of Federal Appeals: Uniformity and Case Management in the Circuit Courts*, 61 DUKE L.J. 315, 328–33 (2011) (providing summary statistics on findings from an investigation of differences in practices across five circuits). In cases concerning constitutional violations, circuit courts have split in opinion and ruled differently based on those splits. See, e.g., Daniel R. Dinger, *Is There a Seat for Miranda at Terry’s Table?: An Analysis of the Federal Circuit Court Split over the Need for Miranda Warnings During Coercive Terry Detentions*, 36 WM. MITCHELL L. REV. 1467, 1570–79 (2010) (providing a detailed summary of how federal circuits differ on whether individuals stopped under the Supreme Court’s standard from *Terry v. Ohio* should receive warnings pursuant to *Miranda v. Arizona* as if they are experiencing custodial interrogations); Wayne A. Logan, *Constitutional Cacophony: Federal Circuit Splits and the Fourth Amendment*, 65 VAND. L. REV. 1137, 1147–56 (2012) (identifying around three dozen circuit splits on Fourth Amendment matters in the federal circuits); Nancy M. Modesitt, *A New Type of Circuit Split: The Hidden Circuit Split in Retaliation Cases*, 68 U. KAN. L. REV. 137 (2019) (generally evaluating the economic effects of the creation of a uniform appellate court for patents); Kelly Sarabyn, *The Twenty-Sixth Amendment: Resolving the Federal Circuit Split over College Students’ First Amendment Rights*, 14 TEX. J. ON C.L. & C.R. 27, 44–48 (2008) (describing the federal circuit split on student free speech in university settings). Within federal drug cases, despite having sentencing guidelines, there are still significant differences in final sentence length across circuit courts. Paula M. Kautt, *Location, Location, Location: Interdistrict and Intercircuit Variation in Sentencing Outcomes for Federal Drug-Trafficking Offenses*, 19 JUST. Q. 633, 644–53 (2002) (analyzing variation in drug-trafficking offense outcomes across and within courts and summarizing methodological approach); Lisa Pasko, *Villain or Victim: Regional Variation and Ethnic Disparity in Federal Drug Offense Sentencing*, 13 CRIM. JUST. POL’Y REV. 307, 313–14 (2002) (describing the study’s methodology).

¹⁵⁴ In doing so, we utilize a methodology that is similar to a prior study in this field. See Kautt, *supra* note 153, at 644–53.

¹⁵⁵ The CDC describes this database as “[a]n interactive, online collection of analysis tools for fatal, nonfatal, and cost of injury data.” Ctrs. for Disease Control, *Web-Based Injury Statistics Query and Reporting System*, CDC, <https://wisqars.cdc.gov> [<https://perma.cc/Q2PX-YN4A>] (last visited Jan. 23, 2026).

CDC uses the cause of death records from death certificates.¹⁵⁶ The database also covers a substantial time period appropriate for evaluation for this study—from 1981 to 2016, measured at the state-by-year level.¹⁵⁷ To account for the other observable factors that might be influencing homicide and suicide rates by state and year, each regression with controls includes the same control variables as a prior study in this field, with some of these variables interpolated or truncated as needed.¹⁵⁸

Our main variable of interest is a dummy variable signifying whether a state is subject to the dangerous patient exception in a given year and thus requires a mental health professional to testify in criminal court against a patient. This dangerous patient exception to confidentiality, or lack of privilege, requires some balancing of competing interests when coding empirically. As explained previously, there are distinct and important nuances between the ruling in the Tenth Circuit, which held that under certain circumstances there is a dangerous patient exception to the psychotherapist-patient privilege, and the Fifth Circuit, which ruled that there is no privilege. While these differences are important to practitioners and measuring empirically each circuit's nuanced rulings would be useful, for empirical practicality and statistical power, we group like rulings together. In this circumstance, we code the Tenth and Fifth Circuits as both ruling in favor of a dangerous patient exception, since their rulings functionally achieve similar results. The advantage is that this allows us a more precise estimate of the effect of the dangerous patient exception. However, this potentially comes at the cost of nuance. Each law is coded based on the current state of the law.

B. Model

Difference-in-difference (D-in-D) regression techniques are one of the most common methods used in empirical legal research to evaluate changes in policy enacted across varying

¹⁵⁶ Edwards, *supra* note 85, at 334 (“The preferred measure of homicides comes from the Web-Based Injury Statistics Query and Reporting System . . .”).

¹⁵⁷ Ctrs. for Disease Control, *supra* note 155 (navigate to “About the Data” to read more about this dataset).

¹⁵⁸ Griffin Edwards et al., *Looking Down the Barrel of a Loaded Gun: The Effect of Mandatory Handgun Purchase Delays on Homicide and Suicide*, 128 *ECON. J.* 3117, 3132 (2018) (including in each regression with controls variables such as the status of the “duty to warn” law in that state, the poisoning death rate, real mental health expenditures, the proportion of the population that is male and over forty-five, the proportion of the population that is African American, the unemployment, the log of the accidental firearm death rate, and the proportion of the state senate and house that is a member of the Democratic Party).

jurisdictions at different times.¹⁵⁹ As applied to a change in law, this methodology first measures the change over time in our outcome variables, homicide and suicide rates, before and after a circuit recognizes the dangerous patient exception. This is the first difference, or the treatment group. This D-in-D methodology then compares this difference to a second difference—in the present case, the change in the same outcome variables over the same time periods in jurisdictions that chose not to recognize the dangerous patient exception. This second difference represents the control group. This methodology then measures the difference between the treatment group and the control group to see if the outcome variable differed significantly in jurisdictions after the recognition of the dangerous patient exception, relative to the control group.

In recent years, several prominent studies have identified potential problems with the way that prior researchers have used D-in-D methodologies.¹⁶⁰ In response, some researchers

¹⁵⁹ In fact, researchers in the past have described D-in-D as the “leading approach” and ‘the showpiece’ in empirical economics—popularity surely earned through its wide range of applicability and relative ease of implementation.” Griffin Edwards & Stephen Rushin, *De-Policing: An Updated Empirical Analysis of Crime and Federal Police Reform*, 82 WASH. & LEE L. REV. 703, 735–36 (2025) (quoting Ariella Kahn-Lang & Kevin Lang, *The Promise and Pitfalls of Differences-in-Differences: Reflections on 16 and Pregnant and Other Applications*, 38 J. BUS. ECON. STAT. 613, 613 (2020)). Of course, a D-in-D methodology could not come close to matching the gold standard of scientific study—the randomized controlled trial. Ideally, we would be able to randomly introduce different policies on the dangerous patient exception across different jurisdictions that are identical across the same time frames. However, that is obviously not an option when conducting backwards-looking examinations of legal changes across varying states or circuits at various times. Nevertheless, the D-in-D methodology attempts to mirror the randomized control trial in some respects, in hopes of creating one of the best forms of social science experiments presently available to researchers in this field. In the case of many social science studies, researchers lack random assignment, and we cannot always be sure that the treatment jurisdictions or sample jurisdictions are generalizable to the population as a whole. We use, in our estimation, the most appropriate methodology and relevant controls to try to address these issues, but recognize the potential shortfalls, like any empirical social science methodology.

¹⁶⁰ See generally Marianne Bertrand, Esther Duflo & Sendhil Mullainathan, *How Much Should We Trust Differences-in-Differences Estimates?*, 119 Q.J. ECON. 249 (2004) (generally raising issues with how prior researchers treated standard errors of regressions and encouraging clustering at the level of treatment). Researchers have also raised concerns about the use of controls in D-in-D contexts. See, e.g., Andrew C. Baker, David F. Larcker & Charles C.Y. Wang, *How Much Should We Trust Staggered Difference-in-Differences Estimates?*, 144 J. FIN. ECON. 370, 372 (2022) (raising concerns about the inclusion of control variables when some assumptions are not present). One of the criticisms levied against the use of D-in-D methods has to do with the “staggered timing nature of many [D-in-D] frameworks.” Edwards & Rushin, *supra* note 159, at 738. A staggered timeline for various policy interventions can lead to so-called “forbidden comparisons.” *Id.* at 739. For a more in-depth discussion of this problem, see also Andrew Goodman-Bacon,

have proposed alternative D-in-D strategies that reduce the potential for bias. Here, we use the estimator proposed by Jeffrey M. Wooldridge, sometimes referenced as a Mundlak regression.¹⁶¹ This technique sidesteps many of the recent criticisms in the theoretical D-in-D literature by replacing a single policy variable that “turns on” when the state/year observation receives the treatment with a series of treatment cohort and year after treatment interactions that are individually estimated and averaged.¹⁶² Operationalized this way, the D-in-D style analysis allows us to compare jurisdictions that adopted the dangerous patient exception to themselves pre-adoption for the first difference. We then compare that to the same difference for non-adopting jurisdictions.¹⁶³ This helps address state-specific, time-invariant unobserved idiosyncrasies as well as unobserved national trends. Formally, we estimate the following equation:

$$\ln(s_{it}) = \alpha + \sum_{i=1998,2008}^{2016} \beta C_i * \gamma_{t \geq 1998,2008} + \theta X_{it} + \gamma_t + \tau_i + C_i + \varepsilon_{it}$$

where $\ln(s_{it})$ is the natural log of the homicide or suicide rate, X is a vector of controls outlined in the Data section, γ is a set of year fixed effects, τ is a set of state fixed effects, and C_i are cohort fixed effects. The estimated effect is the average of coefficients, β , from each cohort by year after treatment fixed effect. While recent advances have introduced alternative dependent variable transformations like inverse hyperbolic sine or quartic

Difference-in-Differences with Variation in Treatment Timing, 225 J. ECONOMETRICS 254 (2021); Brantly Callaway & Pedro H. C. Sant’Anna, *Difference-in-Differences with Multiple Time Periods*, 225 J. ECONOMETRICS 200 (2021); Clément de Chaisemartin & Xavier D’Haultfoeuille, *Two-Way Fixed Effects Estimators with Heterogeneous Treatment Effects*, 110 AM. ECON. REV. 2964 (2020). Additionally, researchers have raised concerns about “the relative weights given to each 2x2 comparison, or the amount each 2x2 comparison contributes to the end estimate.” Edwards & Rushin, *supra* note 159, at 739.

¹⁶¹ Jeffrey M. Wooldridge, *Two-Way Fixed Effects, the Two-Way Mundlak Regression, and Difference-in-Differences Estimators*, (2021), <https://papers.ssrn.com/abstract=3906345> [<https://perma.cc/X4ZZ-MKXR>]; see also Yair Mundlak, *On the Pooling of Time Series and Cross Section Data*, 46 ECONOMETRICA 69 (1978).

¹⁶² See Edwards & Rushin, *supra* note 159, at 737–38.

¹⁶³ Courts follow both horizontal and vertical stare decisis, under which an appellate court and any subordinate court must treat as binding precedent the prior holding of the appellate court in a published opinion. See Charles A. Sullivan, *On Vacation*, 43 HOUS. L. REV. 1143, 1147–48 (2006). All of the opinions on which we rely are published, so their holdings are binding on all federal courts within the appellate courts’ geographical jurisdiction.

regressions¹⁶⁴ which are primarily employed to address zeros in the outcome variables of which there are none in state-level homicides and suicides, logged rates remain standard practice.¹⁶⁵ Each regression is weighted by state population,¹⁶⁶ with standard errors clustered at the state level.

Academic work on the effects of changes in law, particularly laws that affect individuals experiencing a mental illness, usually exploits the variation in laws that occur across states and time, since many laws that affect individuals living with mental illnesses are generally state laws decided by state legislators and/or state courts.¹⁶⁷ In the context of dangerous patient exceptions, we instead exploit the variation in unsettled federal circuit courts. In the present study, the fact that some federal circuits have recognized the dangerous patient exception (or effectively have done so), while others have not, provides a unique opportunity to compare the outcomes in the effect on states over time.

For the results from this study to be valid, that variation must not be endogenous to the outcome variables of interest.¹⁶⁸

¹⁶⁴ See, e.g., Jason M. Lindo et al., *How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions* 47 (Nat'l Bureau of Econ. Rsch., Working Paper No. 23366, 2018), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2961090 [<https://perma.cc/98ZT-PDZ6>] (“[T]his table presents weighted least squares estimates applied to a measure of log abortion rates constructed using the inverse hyperbolic sine function, where the weights are the population of females aged 15-44.”).

¹⁶⁵ See, e.g., Scott R. Baker, *Effects of Immigrant Legalization on Crime*, 105 AM. ECON. REV.: PAPERS & PROCS. 210, 211 (2015) (presenting data with and without non-zero cases because of concern it could skew results; also using such an approach); Edwards & Rushin, *supra* note 159, at 745 n.236 (“[W]here the crime values take a zero, we add an arbitrarily small value in order to be able to calculate the logged crime rate as the outcome. While there are alternative methods to approach the zero dependent variable issue such as a quartic or inverse hyperbolic sine transformation, we wanted to keep this analysis as close to our original analysis and only change the factors, like the estimation technique and improved data, that mattered most.”).

¹⁶⁶ The results for homicides and suicides are generally insensitive in terms of sign to the choice between weighted and unweighted regressions.

¹⁶⁷ See, e.g., Bisakha Sen & Anantachai Panjapapirom, *State Background Checks for Gun Purchase and Firearm Deaths: An Exploratory Study*, 55 PREVENTATIVE MED. 346, 347-49 (2012) (explaining a methodology that includes evaluation of state laws on firearm homicides and suicides); Edwards, *supra* note 85, at 323-25 (describing the state-by-state variation in laws that served as the basis for that study); Griffin Edwards, Tarasoff, *Duty to Warn Laws, and Suicide*, 34 INT'L REV. L. & ECON. 1, 2-4 (2013) (similarly using state variation in laws in such a manner).

¹⁶⁸ Said another way, the results will only be valid to the extent that the unobserved sorting that occurs between states is the result of the federal recognition of the dangerous patient exception (or its equivalent), and not some other variable.

To ensure this endogenous sorting does not occur, we run additional analyses. We predict the adoption of a dangerous patient exception with lagged homicides or suicide rates,¹⁶⁹ and find no evidence that these legal changes were driven in any way by lagged homicides or suicide rates.¹⁷⁰ Even in the most unrealistic empirical settings that might skew the results towards statistical significance, there is no evidence that the uptake of these legal changes is driven by homicide or suicide rates.¹⁷¹ Simply put, judges are not crafting these laws based on a policy endogenous response to homicide or suicide rates.

Another modeling nuance that requires careful consideration is the measurement and determination of the appropriate “second difference,” or the baseline comparison of control states to which we compare the states that allow for the dangerous patient exemption. In this context, the options of baseline groups would be states in circuits without a ruling, states in circuits that have ruled in favor of patient privilege, or some combination of the two. In the results presented in Tables (1) through (6), we report the effect of the dangerous patient exception relative to all other states (including states without an explicit ruling and states with a dangerous patient decision), relative to only states without a ruling, and relative to states in favor of the dangerous patient privilege. As discussed more in the next Part, these various approaches provide relatively consistent results, giving us additional confidence in their validity.

IV

EFFECT OF DANGEROUS PATIENT EXCEPTION

We find that the recognition of the dangerous patient exception is associated with a statistically significant increase in suicide rates relative to our control jurisdictions. We find no effect on homicide rates. The resulting estimation of equation (1) in all its iterations can be found in the Tables (1) and (2) for suicides and homicides. Tables (1) and (2) are organized similarly in that each column represents a unique regression.

¹⁶⁹ If, hypothetically, judges made these decisions *because of* prevailing trends in homicides or suicides, then any effect identified in our study might not be the result of the legal change. Rather, it might simply be the result of a court’s concern about underlying homicides or suicides or suicide trends.

¹⁷⁰ These results are available upon request.

¹⁷¹ For instance, even a linear probability model where you try to predict the uptake of the law with no fixed effects (which most would insist *should* be included), and just a one year lagged log homicide rate, with zero standard error corrections (again, most would agree *should* occur), the sign on the lagged homicide rate is statistically insignificant.

Columns (2), (4), and (6) include the controls listed in the Data subpart, columns (1) and (2) include all states in the regressions, columns (3) and (4) only the dangerous patient exemption states and states with no rulings, and columns (5) and (6) with only the dangerous patient exemption states and the privilege states. Because of the logged nature of the dependent variable, the resulting interpretation of the coefficient of interest is a percent change in the outcome. The subparts that follow breakdown our results in more detail.

A. Effect on Suicides

We begin by estimating the effect of the dangerous patient exception on suicides. The resulting numbers represent percent changes in suicides. Thus, a positive result suggests that suicides have increased after the introduction of the dangerous patient exception, while a negative result would indicate a decline. The table indicates the presence of a result that is statistically significant, or unlikely to be the result of random chance, along with corresponding levels of confidence.

These results for the estimation of equation (1) regarding suicides can be found in Table (1). As seen in Table (1), in basically every specification and iteration we find that providing for a dangerous patient exemption leads to a 4 to 8% increase in the suicide rate. Columns (1) and (2) suggest that compared to all other states, those subject to no ruling and those with state privilege, a dangerous patient exemption leads to an increase of suicides between 5.5 and 6.7%. As seen in columns (3) through (6) this effect persists regardless of the comparison group. These results are consistent with others who predicted adverse consequences from weakening patient protection,¹⁷² and other works that have shown empirically that weakening the doctor-patient relationship leads to more harmful behaviors.¹⁷³

¹⁷² Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 367 (1976) (predicting that an exception to the testimonial privilege “may often render the relationship totally ineffective” and that “[e]ven if it does not have that result, a patient may refrain from expressing feelings which in fact embody no real intention to harm a third party if he must fear that the therapist, impelled by a legal duty, will reveal them to others”).

¹⁷³ See, e.g., Edwards, *supra* note 85, at 337–38 (presenting the results from such an empirical study that found a link between duty to warn and homicides).

Table 1, Effect of Dangerous Patient Exception on Suicides

| Dangerous Patient Exception | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|--------------------|--------------------|--------------------|--------------------|------------|--------------------|
| | 0.067 [^] | 0.055 [‡] | 0.057 [†] | 0.046 [^] | 0.083 | 0.049 [†] |
| | (0.035) | (0.018) | (0.023) | (0.023) | (0.061) | (0.018) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1836 | 1836 | 1116 | 1116 | 1044 | 1044 |
| R Squared | 0.897 | 0.925 | 0.936 | 0.942 | 0.816 | 0.921 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that is democrat. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. [^] p<0.10 [†] p<0.05 [‡] p<0.01

As seen in Table (1), under the assumption for most specifications of our model, we find that the dangerous patient exception is generally associated with an increase in suicides. Our model has varying degrees of confidence in these estimates, with the probability that the resulting relationship is not explainable by mere chance ranging from 90% to 99%, depending on the specifications of various models.

This finding is consistent with some prominent criticisms of the dangerous patient exception. For example, in 2010, the American Psychiatric Association formally adopted a policy document outlining the organization's official position on the dangerous patient exception to the psychotherapist-patient privilege.¹⁷⁴ That policy document laid out numerous objections

¹⁷⁴ Robert Weinstock et al., *supra* note 23 at 1 (explaining the significance of such police statements by quoting the APA Operations Manual as stating that, "[p]olicy documents are approved by the APA Assembly and Board of Trustees" and they represent "APA official policy on specific subjects").

to the exception. Among these, the APA worried that the exception failed to serve any legitimate public safety function, since most states have already adopted requirements that therapy professionals disclose imminent threats to patients or others.¹⁷⁵ Thus, the APA did not believe that there would be any marginal public safety benefit, since it would not affect this pre-existing obligation to act to prevent imminent harm.

Instead, the APA worried that any such exception would “seriously undermine the privilege itself.”¹⁷⁶ This is because therapy and mental health treatment rely on a patient’s “openness in treatment,” which the APA states “can be a prerequisite to resolving the problems leading to potential violence.”¹⁷⁷ In jurisdictions that recognize a dangerous patient exception, therapists’ efforts to notify patients of this newfound legal obligation could therefore chill the therapist-patient relationship.

Our data is consistent with the APA’s hypothesis. If the APA is correct that the dangerous patient exception disincentivizes vulnerable patients from receiving mental health treatment, it seems plausible that this may manifest, over time, in increases in suicide rates as illustrated in Table 1. At the same time, the APA’s position paper also takes issue with the prediction that the exception may contribute to improved public safety. Some supporters of the dangerous patient exception justified its existence, in part, based on a belief that it would protect the safety of others.¹⁷⁸ The next subpart tests this hypothesis by examining the effect of the dangerous patient exception on homicide rates.

B. Effect on Homicides

Unlike suicides, Table (2) reports that, across all specifications, there is no evidence that the dangerous patient exception influences homicides. In each column, the estimated effect is statistically insignificant. And in fact, in one case, the

¹⁷⁵ *Id.* at 2 (“Indeed, most states have adopted some version of a duty for therapists to act in this way.”).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ See *supra* note 21 and accompanying articles that cite this justification for the existence of the dangerous patient exception; Robert Weinstock et al., *supra* note 23, at 2 (“At first glance, it might seem appropriate to recognize an exception to privilege in those rare situations in which testimony in federal court may be sought to prevent a future danger.”).

direction of the effect shifts from positive to negative. Like in Table (1), a positive result would suggest that the dangerous patient exception is associated with an increase in homicides. A negative number would suggest that the dangerous patient exception is associated with a decrease in homicides. Any inconsistency in the direction of an observed effect (e.g., if one model produces a positive result and the other produces a negative result) would reduce our confidence in any relationship between these variables.

Table 2, Effect of Dangerous Patient Exception on Homicides

| Dangerous Patient Exception | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|------------------|------------------|------------------|-------------------|------------------|------------------|
| | 0.029 (0.063) | 0.017 (0.053) | 0.041 (0.080) | -0.011 (0.066) | 0.031 (0.086) | 0.017 (0.048) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1836 | 1836 | 1116 | 1116 | 1044 | 1044 |
| R Squared | 0.907 | 0.930 | 0.910 | 0.933 | 0.905 | 0.941 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that are Democrats. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. ^ $p < 0.10$ † $p < 0.05$ ‡ $p < 0.01$

Table (2) shows no statistically significant relationship between circuits recognizing the dangerous patient exception and subsequent homicide rates. Like the results from Table (1), the results from Table (2) are also potentially consistent with the position taken by the American Psychiatric Association in 2010. That policy document predicted that any public safety benefits of the dangerous patient exception would be minimal, or possibly non-existent, because of the existence of state laws across the country that already require mental health professional action in cases where a client poses an immediate risk of danger to themselves or to others.¹⁷⁹ These may often take the form of civil actions or compulsory hospitalization.¹⁸⁰ Therefore, by recognizing a dangerous patient exception, the APA believed that the marginal public safety benefit of *also* allowing a prosecutor to compel evidence from a therapist about statements made by a patient during treatment would be minimal. As they put it, “such testimony would rarely, if ever, really be needed to avert a future danger, and opening up this possibility has led to an absence of evidentiary privilege after all danger has passed, leaving its real application to determinations of guilt and punishment.”¹⁸¹

C. Feasibility, Robustness, and Event Study

The estimates from Table (2) suggest that states subject to dangerous patient exceptions experience around a 4–8% increase in suicides relative to changes in states that did not experience the same legal change, over the same time-period. But how feasible is it that such a nuanced change in applicable law would produce a measurable impact in this outcome variable over time? As a prior researcher has pointed out, exemptions to doctor-patient confidentiality may impede effective mental health treatment.¹⁸² This assertion is backed up by survey research, which suggests

¹⁷⁹ Robert Weinstock et al., *supra* note 23, at 2 (noting that “most states have adopted some version of a duty for therapists to act in this way”).

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² Edwards, *supra* note 85, at 344 (explaining that that study’s results are “consistent with previous literature suggesting that worsening mental health

that patients are less likely to receive mental health treatment when doctor-patient confidentiality is weakened,¹⁸³ and therapists are less likely to treat dangerous patients.¹⁸⁴

To give us added confidence in the significance of our findings, we re-estimate equation (1) with most of the same parameters as before. However, in these supplemental tables, we replace the outcome variables with other measures of mortality that should not be affected by the legal change. These results are reported in Tables (3) through (6). Each table is organized the same as Tables (1) and (2), just with outcomes that should not be affected by the dangerous patient exemption. These kinds of placebo tests are a common way to test the robustness of an empirical study of this kind.¹⁸⁵

For instance, Table (3) estimates any effect between the dangerous patient exemption and homicides where the victim was unknown to the assailant. It is longstanding tradition that in order for patient privilege to be broken in the context of dangerousness to another, the danger must be real and imminent, and the victim must be readily identifiable.¹⁸⁶ Thus, we should expect that dangerous patient exceptions should not affect homicides committed by strangers because definitionally, if the victim was a stranger, there was no identifiable victim and no justification for breach of duty. Across all specifications in Table (3), we find no evidence of an association between the dangerous patient exception and stranger homicides.

conditions lead to more crime and is plausible given the large number of mentally ill criminals who receive treatment”).

¹⁸³ Edwards, *supra* note 85, at 329 (“In an attempt to avoid liability, a therapist will likely warn the patient *ex ante*, both verbally and by signed contract, of the law to allow the patient to monitor what is divulged. The evidence from previous research suggests that this happens at least in part.” (citations omitted)).

¹⁸⁴ See generally Daniel J. Givelber, William J. Bowers & Carolyn L. Blicht, Tarasoff, *Myth and Reality: An Empirical Study of Private Law in Action*, 1984 WIS. L. REV. 443 (1984) (observing, generally, a 30% decline in willingness to provide care after conducting one of the few empirical studies on the topic of the time).

¹⁸⁵ See, e.g., Griffin Edwards & Stephen Rushin, *The Effect of Police Quota Laws*, 109 IOWA L. REV. 2127, 2178–79 (2024) (utilizing a placebo test that altered the date of the policy enactment).

¹⁸⁶ Michael L. Perlin, Tarasoff and the Dilemma of the Dangerous Patient: *New Directions for the 1990's*, 16 L. & PSYCH. REV. 29, 34–35 (1992) (“Courts have distinguished *Tarasoff* in a variety of cases. Most have involved fact settings where the victim was neither identified nor identifiable. Similar results were reached where: the therapist lacked sufficient control over the patient in question; the therapist could have reasonably believed that the patient’s fantasies did not pose a danger to an identifiable victim” (footnotes omitted)).

Table 3, Effect of Dangerous Patient Exception on Stranger Homicides

| | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|------------------|------------------|------------------|------------------|------------------|-------------------|
| Dangerous Patient Exception | 0.053 (0.053) | 0.026 (0.070) | 0.083 (0.062) | 0.052 (0.086) | 0.029 (0.053) | -0.010 (0.059) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1778 | 1778 | 1065 | 1065 | 1031 | 1031 |
| R Squared | 0.585 | 0.599 | 0.582 | 0.604 | 0.592 | 0.619 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that are Democrats. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. ^ $p < 0.10$ † $p < 0.05$ ‡ $p < 0.01$

Next, in Table (4), we offer additional robustness checks for our results related to suicide. As suicide is a mortality outcome, it could be possible that our estimated results are picking up some nuances in mortality generally that we misidentify as affecting suicides in these jurisdictions specifically. To test for this, we include as placebo outcomes three common and frequently occurring mortality outcomes—automobile deaths, poisoning deaths, and accidental deaths.

The results for this table should be understood much like the earlier tables. In this case, like in Table (3), if we fail to find any statistically significant relationship between the introduction of the dangerous patient exception and these placebo outcomes, that bolsters our confidence in our primary findings.

As seen in Tables (4) through (6), we fail to find any consistent evidence across the different specifications of our model that any of these placebo measures are affected by the timing of the recognition of the dangerous patient exception.¹⁸⁷

Table 4, Effect of Dangerous Patient Exception on Accidental Deaths

| Dangerous Patient Exception | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|-------------------|------------------|------------------|------------------|-------------------|------------------|
| | -1.510 (4.422) | 0.000 (0.000) | 0.158 (6.314) | 0.000 (0.000) | -3.378 (3.131) | 0.000 (0.000) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1836 | 1836 | 1116 | 1116 | 1044 | 1044 |
| R Squared | 0.579 | 1.000 | 0.581 | 1.000 | 0.664 | 1.000 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that are Democrats. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. ^ p<0.10 † p<0.05 ‡ p<0.01

¹⁸⁷ While there are two specifications in Table (5) that are statistically significant, this is not entirely unexpected when running placebo tests. Across Tables (3) through (6) we estimate 24 regressions and found 2 significant results. This is about the rate at which we would expect to find a false positive when hypothesis testing at the 10% level.

Table 5, Effect of Dangerous Patient Exception on Automobile Deaths

| | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|-------------------|-------------------|------------------|-------------------|--------------------|--------------------|
| Dangerous Patient Exception | -0.001 (0.173) | -0.194 (0.133) | 0.299 (0.223) | -0.021 (0.181) | -0.343‡ (0.114) | -0.334‡ (0.101) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1804 | 1804 | 1090 | 1090 | 1038 | 1038 |
| R Squared | 0.610 | 0.683 | 0.586 | 0.714 | 0.813 | 0.839 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that are Democrats. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. ^ $p < 0.10$ † $p < 0.05$ ‡ $p < 0.01$

Table 6, Effect of Dangerous Patient Exception on Poisoning Deaths

| Dangerous Patient Exception | (1) | (2) | (3) | (4) | (5) | (6) |
|-----------------------------|---------|---------|-----------------|-----------------|------------|------------|
| | -0.626 | 0.087 | -0.748 | -0.077 | -0.342 | 0.246 |
| | (0.480) | (0.221) | (0.495) | (0.221) | (0.541) | (0.219) |
| Controls | | X | | X | | X |
| Circuits Included | All | All | DPE & No Ruling | DPE & No Ruling | DPE & Priv | DPE & Priv |
| Sample Size | 1836 | 1836 | 1116 | 1116 | 1044 | 1044 |
| R Squared | 0.676 | 0.859 | 0.685 | 0.859 | 0.675 | 0.913 |

Notes: Each column represents a unique regression. Columns (2) and (4) include the following controls: a control for status of the duty to warn law in that state, the poisoning death rate, real mental health expenditures, proportion of the population that is male and over 45, proportion of the population that is African American, unemployment, log of the accidental firearm death rate, proportion of the state senate and house that are Democrats. Even numbered columns include controls. Columns (1) and (2) include all states as a baseline of comparison. Columns (3) and (4) include just states without any ruling as the baseline. Columns (5) and (6) include states with a privilege ruling as the baseline of comparison. Standard errors, in parentheses, are clustered at the state level to address autocorrelation in the errors. ^ $p < 0.10$ † $p < 0.05$ ‡ $p < 0.01$

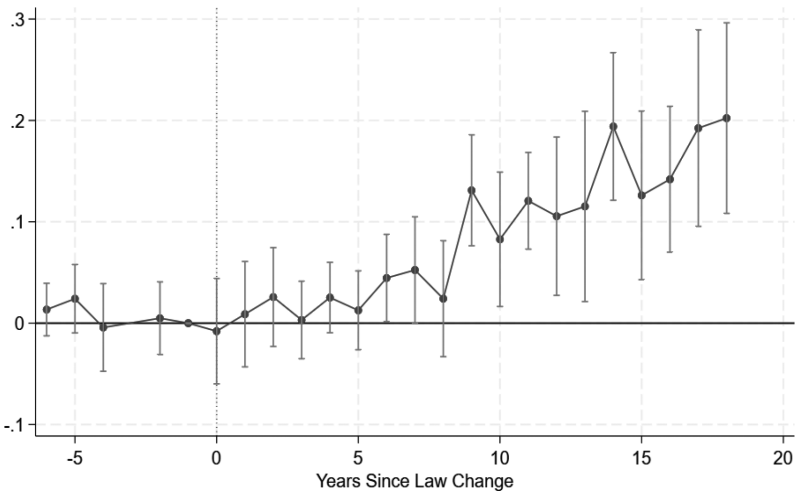
As an additional test of the robustness of our findings, we also conduct two event studies. The results presented in Tables (1) and (2) assume a constant effect of dangerous patient exceptions across years since adoption. To test for a dynamic effect of the dangerous patient exemption that allows the effect to vary over time, we include event study regressions that re-estimate column (3) of Table (1) for suicides and Table (2) for homicides. Prior studies have used this same approach to test the reliability of their primary findings.¹⁸⁸

¹⁸⁸ See, e.g., Stephen Rushin & Griffin Edwards, *An Empirical Assessment of Pretextual Stops and Racial Profiling*, 73 STAN. L. REV. 637, 693–94 (2021) (using a similar approach). See generally Melissa S. Kearney & Phillip B. Levine, *Media Influences on Social Outcomes: The Impact of MTV's 16 and Pregnant on Teen Childbearing*, 105 AM. ECON. REV. 3597 (2015) (using a similar approach in a study of teen pregnancies and the popularity of an MTV television program). See also Edwards et al., *supra* note 158, at 3134–35 (also using a similar method); Griffin Edwards & Stephen Rushin, *Police Vehicle Searches and Racial Profiling: An Empirical Study*, 91 FORDHAM L. REV. 1, 40–42 (2022) (using event studies in a similar manner).

In the context of the Mundlak regression approach, the only alteration in these event studies is the addition of pre-treatment cohort-by-year effects to test for the parallel trends assumption, and the way in which we average the estimated coefficients. In the main results, we average all effects across time and across cohorts. To generate event study results, we calculate the effect-by-year since treatment by averaging cohort-by-year effects for each cohort. The dynamic effect of the dangerous patient exception on suicides is displayed graphically in Figure (1) and in Figure (2) for homicides.

In each figure, the vertical axis reports the effect size as measured in percent changes. The horizontal axis measures years before and after adoption. Each point is the effect at the corresponding centered year. The bands represent 90% confidential intervals. Thus, in Figures (1) and (2), the effect of the dangerous patient exception is considered statistically significant, using this 90% confidence interval as our standard, any year the vertical red confidence interval is entirely above or below zero. As is customary, the last complete year prior to adoption is left out as the comparison group.

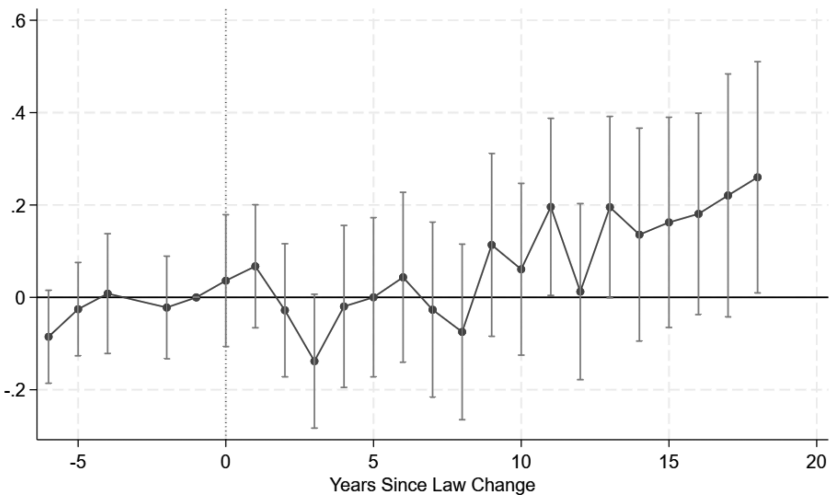
Figure 1: Event Study of Suicide Rates¹⁸⁹



¹⁸⁹ Each dot in Figures 1 and 2 represents a coefficient in time and the bands represent the 90% confidence interval with the last complete year prior to adoption left out as a comparison group.

As is seen in Figure (1), all years prior to adoption are statistically insignificant suggesting there is no systematic difference between adopting and non-adopting states prior to legal change. After the legal change, the effect on suicides grows as time passes, and becomes statistically significant around 5–10 years after the introduction of this change in law in affected jurisdictions, as illustrated by the fact that the error bars sit fully above the horizontal line representing zero. By years 11–18, the increase in suicides increases, as does our confidence in the significance of this finding, as the error bars sit well above zero. Figure (2) replicates this same methodology but examines the effect of the dangerous patient exception by year on homicides.

Figure 2: Event Study of Homicide Rates



And as seen in Figure (2), the confidence intervals around homicides do not show any statistical significance consistently throughout the time frame that we study, as these vertical lines consistently extend above and below zero. This means that we cannot say, with any level of certainty, that the dangerous patient exception is influencing homicide rates. While this does not fully reject the possibility that the two variables are in some way related, our model does not give us evidence to support such a finding.

Combined, these results from Figures 1 and 2 provide additional confidence in the robustness of our results. These results suggest that, to the extent the dangerous patient exception has influenced suicide rates in affected jurisdictions,

it may have taken time for states to feel this effect.¹⁹⁰ The next Part considers the implications of these findings for the Federal Rules of Evidence and the potential extension of the dangerous patient exception in future cases.

V

IMPLICATIONS AND LIMITATIONS

Our findings favor the conclusions of the Sixth, Eighth, and Ninth Circuits, as well as critical assessments of the dangerous patient exception from groups like the American Psychiatric Association. The net increase in suicides that exists in jurisdictions with a *de facto* or *de jure* dangerous-patient exception to the federal psychotherapist-patient privilege may disincentivize vulnerable patients from receiving or continuing treatment. This, in turn, may be contributing to the subsequent increase in suicide rates in our treatment group. This finding has important implications for the future of the dangerous patient exception, as well as the broader study of law and mental health.

First, our findings should caution future courts against the recognition or extension of the dangerous patient exception. Thus far, most federal circuits have not issued a holding on the dangerous patient exception.¹⁹¹ Lawyers, academics, and medical professionals have widely debated the merits of the dangerous patient exception.¹⁹² Several commentators have also predicted that, given the existing circuit split on this important issue, the U.S. Supreme Court may or should eventually step in to resolve the matter.¹⁹³ While our study is far from

¹⁹⁰ This delayed impact may be consistent with a change in law that takes time to be communicated in mental health professionals and eventually alter behavior in future patient sessions.

¹⁹¹ This includes the First, Second, Third, Fourth, Seventh, Eleventh, and DC Circuit Courts of Appeal. These circuits include the states of Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Maine, Maryland, Massachusetts, North Carolina, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, South Carolina, Vermont, West Virginia, Wisconsin, as well as Puerto Rico and the District of Columbia.

¹⁹² See, e.g., Appelbaum, *supra* 73, at 715–16 (providing a summary of the arguments for and against the recognition of the exception); Huston Combs, Note, *Dangerous Patients: An Exception to the Federal Psychotherapist-Patient Privilege*, 91 Ky. L.J. 457, 469–76 (2002) (providing a background on how courts reached different conclusions on the extension of this exception).

¹⁹³ Philip A. Sellers II, *United States v. Landor: The Federal Circuit Split over the Dangerous Patient Exception to the Psychotherapist-Patient Privilege*, 34 Am. J. TRIAL ADVOC. 417, 431 (2010) (“It is particularly important that the Supreme Court resolve this split, as the definition of a licensed psychotherapist continues to expand to encompass more types of professional counselors. Consequently,

dispositive on the matter, we believe it generally cuts against the case for recognizing the dangerous patient exception in two ways.

To begin with, our study provides some empirical support for assumptions made by the Sixth, Eighth, and Ninth Circuit decisions electing not to recognize the dangerous patient exception, specifically the assumption that the exception's recognition may discourage vulnerable patients from receiving care. As the Sixth Circuit predicted in *Hayes*, recognition of a dangerous patient exception may "have a deleterious effect on the 'atmosphere of confidence and trust' in the psychotherapist/patient relationship."¹⁹⁴ That court predicted that, because therapists already have existing obligations to disclose dangerous patients for purposes of civil commitment or civil liability, adding on an additional risk that a therapist's testimony or notes may lead to the criminal incarceration of a patient "certainly chill and very likely terminate open dialogue."¹⁹⁵ Similarly, in *Chase*, the Ninth Circuit expressed concern that the recognition of a dangerous patient exception would undercut the stated purposes of the psychotherapist-patient privilege—"to improve public health."¹⁹⁶ If patients were made aware that their therapist may testify against them in future criminal proceedings, this would have an "adverse effect on the candor that the psychotherapist-patient privilege is meant to encourage."¹⁹⁷ This is "because patients will be more reluctant to divulge unsavory thoughts or urges if they know that the therapist may be required to testify about the content of therapeutic sessions."¹⁹⁸ Thus, they worried that the recognition of the exception would reduce the prevalence of patients receiving care. The Ninth Circuit worried, further, that when taken to its logical extension, the recognition of the exception would lead to more patients experiencing criminal punishment for comments made during treatment, and that "[a] criminal conviction with the help of a

defendants will likely attempt to assert the privilege under new and increasingly complex circumstances." (footnote omitted)). See also Appelbaum, *supra* note 73, at 716 ("With the split among the federal circuits, it seems clear that the U.S. Supreme Court ultimately will need to speak to the question of whether a dangerous patient exception exists in the federal courts and, if so, what its dimensions may be.").

¹⁹⁴ United States v. Hayes, 227 F.3d 578, 584 (6th Cir. 2000).

¹⁹⁵ *Id.* at 585.

¹⁹⁶ United States v. Chase, 340 F.3d 978, 990 (9th Cir. 2003).

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

psychotherapist's testimony is almost sure to spell the end of any patient's willingness to undergo further treatment for mental health problems."¹⁹⁹

All these courts essentially predict that, were they to recognize the dangerous patient exception, patients would become aware of this fact (perhaps through affirmative warnings provided by their therapist), which would, in turn, chill open dialogue during treatment or otherwise discourage future treatment. It would follow, then, that without that open dialogue or willingness to continue care, we may experience a small but measurable increase in harmful outcomes like suicide that are often associated with mental health issues. Our data is consistent with this hypothesis, as it shows a small, but statistically significant increase over time in suicide rates in jurisdictions that adopt the dangerous patient exception, as compared to those that do not.

Additionally, the Sixth, Eighth, and Ninth Circuits all expressed skepticism that the recognition of a dangerous patient exception would have any public safety benefit to the population generally. This is because, as each circuit correctly pointed out, mental health professionals already have a civil and professional duty to warn in cases of an imminently dangerous client.²⁰⁰ As the Sixth Circuit in *Hayes* pointed out, "[t]he obvious rationale behind this rule is that the preservation and protection of the health and safety of innocent third parties outweighs the good achieved by maintaining the confidentiality of life-threatening communications."²⁰¹ Because such duties already exist across the country to prevent a patient from carrying out harm to an identifiable person, circuit courts that have rejected the dangerous patient exception did so, in part, because they believed that its recognition would not do much to prevent violence against others. By the time a prosecutor attempts to take advantage of the dangerous patient exception, the immediate threat to another person has likely ended.²⁰²

If these assumptions are true, we might expect the recognition of the dangerous patient exception to not contribute to any noticeable benefit for public safety broadly, as measured by violence against others. In our data, we find no association

199 *Id.* at 991.

200 *United States v. Hayes*, 227 F.3d 578, 583 (6th Cir. 2000).

201 *Id.*

202 *Chase*, 340 F.3d 990 (explaining that, at the point of the application of the dangerous patient exception, the focus is not on protecting someone from imminent harm, but instead punitive or punishment purposes).

between the recognition of the exception and subsequent homicide rates, or stranger homicide rates. This makes some logical sense, in an environment where a civil and professional duty to warn already exists to limit immediate harm to others, and the exception will mostly exist for long-term punishment purposes. Thus, all our empirical evidence is mostly consistent with the predictions and assumptions offered by the Sixth, Eighth, and Ninth Circuits.

Of course, we recognize the limits of any single empirical, social science study. Our results are far from a randomized controlled trial and thus should be viewed as “one data point in what will hopefully be a growing literature” as future courts weigh the various legal and policy arguments related to the dangerous patient exception.²⁰³

Second, we have only limited evidence on the extent to which mental health professionals are aware of the changes in law at the federal circuit level related to the dangerous patient exception. One meta-analysis examined a closely-related question—how widely understood among mental health professionals is the legal duty to provide so-called *Tarasoff* warnings (or their equivalents).²⁰⁴ That study found that “[b]etween 50% and 90% of clinicians (except nurses) . . . reported that they would inform the patient if disclosure of information were to occur in an effort to preserve their ethical principals [sic].”²⁰⁵ Existing studies have also shown a near-universal understanding among mental health professionals about their ethical obligation to warn, with various studies finding this knowledge was present in generally over 90% of respondents.²⁰⁶ This makes sense, in part because knowledge of the general duty to warn

²⁰³ Stephen Rushin & Griffin Edwards, *De-Policing*, 102 CORN. L. REV. 721, 772 (2017) (also offering a similar suggestion in situating that paper within the broader policy and empirical debate over crime and police regulation).

²⁰⁴ Elizabeth Henderson, *Potentially Dangerous Patients: A Review of the Duty to Warn*, 41 J. EMERGENCY NURSING 193, 194–96 (2015) (showing a table listing the prior studies included in this analysis).

²⁰⁵ *Id.* at 197.

²⁰⁶ *Id.* There was some nuance in the findings developed by different studies and methodologies. As that meta-analysis found,

[E]mpirical evidence reveals that awareness of the *Tarasoff* decision effectively permeated the clinical arena. Two nationwide studies examined psychologists’ knowledge of the *Tarasoff* decision, revealing that an overwhelming majority (>90%) had heard of and possessed a working knowledge of the *Tarasoff* decision. Similarly, in two smaller scale studies, clinicians also reported an overwhelmingly positive response (96.1% and 91%, respectively) around their knowledge of the *Tarasoff* case.

Id. (citations omitted).

is highly rational for providers who want to avoid legal liability²⁰⁷ and because throughout this time period, “technology has markedly improved, allowing real-time communication of legal and professional updates via modern social media forums and professional organization websites.”²⁰⁸

However, this study is focused not on the effect of a *duty to warn*, but instead on the effect of the extension of the *dangerous patient exception*. While a strong body of evidence shows rapid proliferation of knowledge of such legal rules to the mental health professional field in the digital age, we must recognize two additional possibilities. For one thing, as the author of the aforementioned meta-analysis explained, while technology has improved the communication of new legal rules, it may be possible that today “the pendulum has . . . swung in the opposite direction, with information overload and technological saturation making it a challenge to stay abreast of relevant legal decisions and professional legal requirements in light of the competing professional demands experienced by the modern clinician.”²⁰⁹ Additionally, the nuances of the dangerous patient exception are less understood by the mental health professionals, as “accurate comprehension of legal statutes can be difficult for persons unfamiliar with legal language and terminology.”²¹⁰

Future studies may examine the extent to which mental health professionals are aware of changes in federal circuit law on the dangerous patient exception that may impact them or their clients. Future studies may also consider how and if this knowledge of the law impacts the warnings that therapists provide to their patients at any point during treatment. Evidence linking this change in law with measurable changes in the behavior of mental health professionals would further bolster the plausibility of the empirical link between the dangerous patient exception and suicides that we observe in this study.²¹¹

²⁰⁷ *Id.* at 198–99 (describing the standard for liability and desire to avoid such liability).

²⁰⁸ *Id.* at 199.

²⁰⁹ *Id.* On the other hand, it is worth pointing out that, should this cause a delay in the communication of the rule to this professional field, that might explain why the effect on suicides that we demonstrate is delayed somewhat from the initial circuit court opinion date.

²¹⁰ *Id.*

²¹¹ Additionally, further studies may consider alternative methodologies to examine the same fundamental empirical question examined in article, by looking at the timing of state variation in the dangerous patient exception, and subsequent changes in related outcomes. It is also worth mentioning that most criminal cases are brought at the state, not federal level. Given this reality, we must further acknowledge that the impact of the recognition of a dangerous patient

Third, we recognize there may be circumstances where the failure to apply something akin to the dangerous patient exception may seriously impede justice. All federal circuit cases discussed in this Article that considered the dangerous patient exception have done so in the context of a threat that was never acted upon by the patient. As some courts and commentators have noted, the balance of public interests may shift dramatically once the patient follows through on his threats.²¹² For example, imagine that hypothetical Patient X tells a therapist confidentially that he will place a bomb in a subway station after he leaves the appointment. The therapist races to make a *Tarasoff* disclosure to local law enforcement, but it is too late. Patient X places a bomb in the nearby subway station and detonates it. Death and destruction follow. In the days that follow, no other evidence emerges to identify Patient X as the bomber.

In this scenario, the probative value of the therapist's testimony is high and may well overcome the need to protect Patient X's communications. In *Jaffee*, the Court rejected the use of any ad hoc, case-by-case balancing test that would "[make] the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure."²¹³ The Court reasoned that "if the purpose of the privilege is to be served, the participants in the confidential conversation 'must be able to predict with some degree of certainty whether particular discussions will be protected.'"²¹⁴ To provide this sort of certainty, the courts have generally announced exceptions to general rules of privilege in categorical terms.²¹⁵

exception may be less understood by practitioners than when such an exception is recognized by the state law.

²¹² *United States v. Auster*, 517 F.3d 312, 319–20 (2008) (stating that "[t]he slight marginal therapeutic benefit of allowing the therapist to divulge confidences and to testify in civil commitment hearings, but not in federal criminal trials, must then be weighed against the marginal increase in 'having truth vindicated and justice done,'" and then explaining the unique benefits that compelled testimony from a therapist in a case like this one would advance justice (quoting *United States v. Chase*, 340 F.3d 978, 997 (9th Cir. 2003))).

²¹³ *Jaffee v. Redmond*, 518 U.S. 1, 17–18 (1996).

²¹⁴ *Id.* at 18 (quoting *Upjohn v. United States*, 449 U.S. 383, 393 (1981)).

²¹⁵ *See, e.g., In re Grand Jury Proceedings (Violette)*, 183 F.3d 71, 74–79 (1st Cir. 1999) (announcing more clearly the crime-fraud exception to *Jaffee* and ultimately concluding "we hold that the psychotherapist-patient privilege, like the attorney-client privilege, is subject to a crime-fraud exception; that the district court did not abuse its discretion either in finding the crime-fraud exception applicable to the subpoenaed evidence or in enforcing the subpoenas issued to the two psychiatrists").

In this regard, even courts persuaded by our findings or the legal reasoning of courts that have chosen to not recognize a dangerous patient exception may pause before extending the privilege too far. Presented with a case in which the only crime alleged is the making of threatening language itself, a court may be wise to limit its holding to circumstances where the threat was never acted upon. Courts presented with a scenario in which the threat was carried out, such as the bombing hypothetical, may be wise to consider a narrow exception for completed crimes.

CONCLUSION

Since the U.S. Supreme Court's recognition of the psychotherapist-patient privilege in *Jaffee*, circuit courts have split on whether this privilege should be an exception for so-called dangerous patients. Underlying this debate among the federal circuits have been underlying assumptions about how such an exception may impact patient health and public safety. This Article is the first to present some empirical tests of these underlying assumptions. We find that the recognition of the dangerous patient exception, or its equivalent, is associated with a statistically significant increase in suicides. However, we find no relationship between the dangerous patient exception and subsequent homicides. Combined, these results are generally consistent with criticisms of the dangerous patient exception and should caution courts against extending it in future cases. With the looming possibility that the U.S. Supreme Court will eventually step in to resolve this circuit split, our results provide useful empirical evidence on the potentially harmful effects of extending this exception nationwide.