

# Maas v. UPMC: Muddying The Waters Of Therapist Liability In Pennsylvania

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## ABSTRACT

*In Maas v. UPMC, the Pennsylvania Supreme Court drastically expanded the circumstances under which mental health treatment providers can be held liable for their patients' violent acts. There, a patient who had revealed recurring thoughts of killing unspecified "neighbors" murdered a young woman who lived down the hall. The Court found that, by failing to issue warnings to all tenants in the patient's apartment building, the therapists could be held liable for the woman's death.*

*Pennsylvania has codified a strong policy toward safeguarding the rights of people with mental illness, providing that treatment in the least restrictive environment is always preferred. Before Maas, therapists owed a duty to warn identifiable targets of a patient's threats if the threats were serious, specific, and immediate. The earlier precedent was an attempt to strike a balance between preserving the confidential therapeutic relationship, protecting patient rights, and reducing risk to society.*

*In expanding therapists' duty to encompass unspecified members of an undefined group, the Maas Court disrupts that balance, intruding upon the therapist/patient relationship, and holding therapists responsible for the risks to society inherent in protecting patients' rights.*

*This article explains the development of "duty to warn" cases in the context of statutory authority governing mental health procedures, discusses the harmful implications of expanding therapist liability, and suggests legislative solutions to address the issue.*

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### I. INTRODUCTION

In 1976, the California Supreme Court handed down a decision that caused alarm and anxiety for mental health practitioners across the country. *Tarasoff v. Regents of the University of California*,<sup>2</sup> imposed a legal duty upon

**The Court has contorted the duty of mental health treatment providers to warn possible victims so that its scope can be discernable only in hindsight.**

California therapists<sup>3</sup> to “exercise reasonable care” to protect third parties from their patients’ potential future violence or face personal liability for failing to do so.

*Tarasoff* was followed by an avalanche of commentaries, mostly negative. Therapists protested that the ruling unreasonably intruded into the confidential therapist/patient relationship and required nothing short of clairvoyance. Analysts predicted that patients would withhold important information from their therapists or would avoid treatment entirely. Many worried that those most in need of treatment would be

rejected by liability-conscious providers.

Despite the negative reactions, courts and legislatures in almost every United States jurisdiction have adopted some version of the rule. In the almost half-century since the case was decided, *Tarasoff* has gained a solid foothold in American law.

Pennsylvania courts managed to avoid taking a position on *Tarasoff* until 1998, when the Supreme Court finally addressed the issue in *Emerich v. Philadelphia Center for Human Development, Inc.*<sup>4</sup> The *Emerich* Court, balancing competing policy interests, attempted to adopt a circumspect version of the rule, holding that a Pennsylvania therapist would be required to warn an identifiable target if a patient’s threat was serious, specific, and immediate. The rule remained intact for another two decades.

Last year, in *Maas v. UPMC*,<sup>5</sup> the Pennsylvania Supreme Court expanded therapists’ duty toward third parties when a patient expressed a desire to kill unnamed neighbors. By a vote of 3-2 (two justices did not participate), the Court found the threat specific enough to require the treatment providers to warn all residents of the patient’s apartment building. The duty imposed in *Maas* departs so significantly from Pennsylvania precedent that it would be unrecognizable to the *Emerich* Court.

To fully appreciate the implications of *Maas*, one must understand both *Tarasoff* and *Emerich* within the context of the legislation governing mental health procedures that set the stage for this line of cases.

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

3. The terms “therapist” and “mental health treatment provider” are used generically and interchangeably to refer to the range of mental health professionals who provide direct patient care.

4. 720 A.2d 1032 (Pa. 1998).

5. 234 A.3d 427 (Pa. 2020).

## II. THE LEGISLATIVE LANDSCAPE BEHIND THE DUTY TO WARN

Until recently in our country's history, forcing people to undergo mental health treatment was not difficult. A patient referred by a physician for inpatient mental health care was presumed incompetent, and decision-making authority was transferred to family members, physicians, or the state as *parens patriae*. Inpatient hospitalization, if recommended, was generally accepted to be in the patient's best interest.<sup>6</sup>

In 1975, the United States Supreme Court set new standards for civil commitment in the case of *O'Connor v. Donaldson*.<sup>7</sup> Kenneth Donaldson, a patient diagnosed with paranoid schizophrenia, was involuntarily hospitalized for 15 years under the direction of his treating psychiatrist, despite an absence of any evidence that he was dangerous to himself or anyone else. The Supreme Court held that, if an individual does not pose a threat to himself or others and can live without state supervision, the state has no right to commit him to a facility against his will.

Even before *O'Connor*, as the disability rights movement gained traction, states began tightening restrictions on involuntary treatment. California was the first to pass legislation overhauling its mental health procedures with the Lanterman-Petris-Short Act.<sup>8</sup> The trend continued, as state after state began to heighten civil commitment standards. In 1976, Pennsylvania passed the Mental Health Procedures Act,<sup>9</sup> one of the most restrictive statutes in the country regulating involuntary mental health treatment.

The Pennsylvania legislature not only adopted the *O'Connor* standards, but required more than a threat of harm to support involuntary civil commitment. According to the statute, one may be made subject to involuntary examination and treatment only when, as a result of mental illness, the person poses a clear and present danger to himself or others:

(b) Determination of Clear and Present Danger.—(1) Clear and present danger to others shall be shown by establishing that within the past 30 days the person has inflicted or attempted to inflict serious bodily harm on another and that there is a reasonable probability that such conduct will be repeated. . . . For the purpose of this section, a clear and present danger of harm to others may be demonstrated by proof that the person has made threats of harm **and** has committed acts in furtherance of the threat to commit harm.<sup>10</sup>

The Pennsylvania legislature codified the policy favoring voluntary over involuntary treatment, stating "in every case, the least restrictions consistent with adequate treatment shall be employed."<sup>11</sup> To that end, mental health practitioners involved in decisions related to a patient's level of treatment were granted qualified immunity from liability, should a negative outcome result.<sup>12</sup> Pennsylvania's restrictive commitment procedure has remained in place since its adoption.

6. Stephen D. Roberts, *O'Connor v. Donaldson: One Flew Out of the Cuckoo's Nest*, 37 Montana L. Rev. 14 (1976).

7. 422 U.S. 563 (1975).

8. Cal. Welf. & Inst. Code §§5000-5556 (1967).

9. Act of July 9, 1976 (P.L. 817, No. 143), P.S. §§7101-7503 (hereinafter, "MHPA").

10. 50 P.S. §7301 (2021 P.P.) (emphasis added).

11. 50 P.S. §7102 (2001).

12. 50 P.S. §7114(a) (2001) provides:

Immunity from Civil and Criminal Liability.—

(a) In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise

### III. THE TARASOFF CASE

Although *Tarasoff* has been a staple in law school curricula since it was decided in 1976, the facts and holding of the case have often been misstated, causing confusion for lawyers and mental health professionals alike. A brief review is provided here.<sup>13</sup>

In 1967, Prosenjit Poddar, a native of Bengal, India, entered graduate school at the University of California at Berkeley, where he met Tanya Tarasoff. Poddar developed a romantic interest in Tarasoff, but she turned him down.

Following the rejection, Poddar became depressed and eventually entered psychotherapy with Dr. Lawrence Moore, a clinical psychologist at the campus health center.

In August of 1969, Poddar informed Dr. Moore that he was going to kill a girl when she returned from spending the summer in Brazil. Based on their prior sessions, the therapist knew the woman was Tanya Tarasoff. The therapist took his patient's threats seriously, and after consulting with two psychiatrists, determined that Poddar should be involuntarily hospitalized.

Dr. Moore advised the University's campus police that, in his opinion, Poddar was suffering from acute paranoid schizophrenia and requested assistance in securing his commitment. The police interviewed Poddar, but, finding him rational and believing his promise to stay away from the woman he had threatened, they released him. Dr. Moore's request for civil commitment was denied, and Poddar never returned to therapy.

Two months later, Poddar appeared at Tarasoff's house. When she refused to speak to him, he shot her with a pellet gun and then stabbed her to death.

Poddar was tried and convicted of second-degree murder, but the California Supreme Court reversed his conviction based on a faulty jury instruction. After the prosecution declined to retry him, Poddar was released and returned to India.

Tanya Tarasoff's parents sued the University of California, Dr. Moore, the psychiatrists involved in the commitment attempt, and the campus police, claiming they were negligent in failing to secure Poddar's commitment, in failing to warn of the threat to their daughter, and in failing to protect the public from a dangerous patient. The trial court dismissed the complaint.

On appeal, the California Supreme Court affirmed the dismissal of the claims against the treatment providers for failing to secure Poddar's involuntary commitment. The Court cited the California Tort Claims Act, which afforded immunity from liability for "any injury resulting from determining . . . whether to confine a person for mental illness"<sup>14</sup> pursuant to the Lanterman-Petris-Short Act.

The claims were reinstated against Dr. Moore and the psychiatrists for failing to warn Tarasoff of the danger posed by Poddar and for failing to protect her. Because such actions were not related to the level of Poddar's treatment, the treatment providers would not be insulated from liability on those counts.<sup>15</sup>

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reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

13. The facts and procedure set forth here are compiled from various sources, including *People v. Poddar*, 518 P.2d 342 (Cal., 1974); *Tarasoff*, 551 P.2d 334 (Cal. 1976); LEON VAVDECREEK & SAMUEL KNAPP, *TARASOFF AND BEYOND: LEGAL & CLINICAL CONSIDERATIONS IN THE TREATMENT OF LIFE ENDANGERING PATIENTS* (Sarasota, Florida, Professional Resource Exchange 1989); and Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 Harv. L. Rev. 358 (1976).

14. California Tort Claims Act, Gov. Code, §856 (1963).

15. *Id.*

The first decision of the California Supreme Court found that the therapist breached a duty to warn Tarasoff of Poddar's threat of violence.<sup>16</sup> After the decision was announced, various organizations of mental health professionals petitioned the Court to reconsider the ruling, to which the Court agreed.

The American Psychiatric Association (APA) presented extensive research demonstrating that therapists are unable to predict future violence with any degree of accuracy, that they tend to overpredict violence, and that, in fact, they are more often wrong than right in their predictions.<sup>17</sup> Because therapists cannot forecast when a patient will become violent, the Association argued, they should not be held to a standard requiring them to do just that.

The California Supreme Court vacated its decision, but in its subsequent ruling, no doubt to the dismay of the petitioners, further expanded the duty of California therapists:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to *protect* the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of the various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.<sup>18</sup>

Although generally the law does not hold one responsible for the actions of another, the Court determined a duty to protect third parties arose from the special relationship created by the therapist/patient alliance. Justifying the result, the Court stated: "this risk-infested society . . . can hardly tolerate the further exposure to danger that would result from concealed knowledge of a therapist that his patient was lethal."<sup>19</sup>

The justices were not persuaded by the research findings offered by the APA, but equated the role of mental health practitioners in predicting patients' future violence with that of physicians who must make diagnoses and prognoses based on the standards of the profession:

We recognize the difficulty that a therapist encounters in attempting to forecast whether a patient presents a serious danger of violence. Obviously we do not require that the therapist, in making that determination, render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [the profession] under similar circumstances." Within the broad range of reasonable practice and treatment in which professional opinion and judgment may differ, the therapist is free to exercise his or her own best judgment without liability; proof, aided by hindsight, that he or she judged wrongly is insufficient to establish negligence.<sup>20</sup>

The dissenting justices, by contrast, accepted the argument of the APA and identified a flaw in the majority's reasoning: if no standard exists within the profession

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16. Tarasoff v. Regents of the University of California, 529 P.2d 553 (Cal. 1974).

17. Brief for The American Psychiatric Association as Amicus Curiae Supporting Petitioners, Tarasoff v. Board of Regents of the Univ. of Cal., 551 P.2d 334 (Cal. 1976), citing JOHN MONAHAN, THE PREVENTION OF VIOLENCE IN COMMUNITY MENTAL HEALTH IN THE CRIMINAL JUSTICE SYSTEM (Pergamon Press 1975); Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness*, 123 U.Pa.L.Rev. 439 (1975); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974).

18. *Tarasoff*, 551 P.2d at 340 (emphasis added).

19. *Id.* at 347.

20. *Id.* at 345 (quoting *Bardessono v. Michaels*, 478 P.2d 480, 484 (Cal. 1970)).

for accurately predicting violence, therapists should not be held liable for violating it. One justice suggested an alternative rule: if the therapist *did in fact* predict that the patient would become violent, a duty to warn the intended victim would arise. "The majority's expansion of that rule will take us from the world of reality into the wonderland of clairvoyance."<sup>21</sup>

When *Tarasoff* was decided, Harvard Professor Alan A. Stone, M.D., explained his view of the impetus behind the decision:

The *Tarasoff* decisions are the product of a court unwilling to admit the consequences for public safety of the recent general trend, in which it has played a substantial role, toward increasing recognition of the rights of the mentally ill and the resulting change in civil commitment procedures. The California legislature was in the vanguard of these developments. In passing the Lanterman-Petris-Short Act, it made civil commitment more difficult to initiate and even more difficult to prolong. Indeed, the Poddar case is an example of these new difficulties of initiating commitment. . . . These sweeping changes mean that society must tolerate greater disturbance in the community and greater risk of harm to the public. Attempts like that of the *Tarasoff* court to avoid these results by exposing therapists to greater liability are self-defeating for, because of its effect on both therapists and patients, the imposition of a duty to warn third parties will result in a lower level of safety for society.<sup>22</sup>

This observation appears to be as apt today as it was after *Tarasoff* was decided, as illustrated by the *Maas* case.

#### IV. THE AFTERMATH OF TARASOFF

Four years after the ruling, the California Supreme Court limited the scope of the *Tarasoff* duty to situations in which a clear threat is made to a specific, or easily identifiable, individual. In *Thompson v. County of Alameda*,<sup>23</sup> the Court dismissed a claim against treatment providers after a juvenile inpatient threatened to harm a "child in the neighborhood" and within hours of his release from the hospital, he killed a child who lived a few doors from his residence. The Court ruled for the therapists, holding, "nonspecific threats of harm against nonspecific victims" do not trigger the duty of care,<sup>24</sup> and general warnings to the public of all persons in the community who might pose a danger would "produce a cacophony of warnings that by reason of their sheer volume would add little to the effective protection of the public."<sup>25</sup>

21. *Id.* at 354 (Mosk, J., concurring and dissenting). Had this suggested rule been adopted, the outcome would have been the same. The therapist did predict Poddar would act on his threat but did not warn the intended victim.

22. Stone, *supra* note 13 at 364-365. Stone's prediction seems to have been borne out in subsequent research. In a survey of psychotherapists conducted shortly after *Tarasoff*, 27% reported increasing focus on patient dangerousness during sessions, 25% reported losing a median of three patients after learning certain information would not remain confidential, and an equal number of therapists reported patients were reluctant to discuss violent thoughts after learning of the exceptions to confidentiality. Ten years later, therapists reporting an increased focus on dangerousness rose to 37%. Brian Ginsberg, *Tarasoff at Thirty: Victim's Knowledge Shrinks the Psychotherapist's Duty to Warn*, 21 J. Contemp. Health L. & Pol'y 1 (2004), citing Toni Pryor Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 Stan.L.Rev. 165 (1978) and D.L. Rosenhan & Terri Wolff Teitelbaum, *Warning Third Parties: The Ripple Effects of Tarasoff*, 24 Pac. L. 1165 (1993). More recently, using complex statistical modeling, researchers found that mandatory *Tarasoff* laws were associated with a 5% increase in homicide rates. Griffin Edwards, *Doing Their Duty: An Empirical Analysis of the Unintended Effect of Tarasoff v. Regents on Homicidal Activity*, 57 J. Law & Econ. 321 (2014).

23. 614 P.2d 728 (Cal. 1980).

24. *Id.* at 735.

25. *Id.* at 754-755.

California later codified the holdings of *Tarasoff* and *Thompson*, providing psychotherapists may only be held liable for failing to predict or protect another from a patient's violent behavior "if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. . . . [The psychotherapist] discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency."<sup>26</sup>

Since *Tarasoff*, almost every state in the country has grappled with the question of whether, and how, to apply the ruling, and most have developed standards through case law, legislation, or both.<sup>27</sup> Although the standards have been far from consistent, the majority of states that recognize a *Tarasoff*-type duty limit it to situations in which the patient has communicated to the therapist a serious threat of violence against a reasonably identifiable victim or victims.<sup>28</sup>

## V. THE DUTY TO WARN IN PENNSYLVANIA

Despite several opportunities to do so,<sup>29</sup> the Pennsylvania Supreme Court did not enter the fray until 1998, when it decided *Emerich v. Philadelphia Center for Human Development*.<sup>30</sup>

Gad Joseph received outpatient care for severe mental illness at the Philadelphia Center for Human Development. One morning, Joseph telephoned his therapist, Anthony Scuderi, and told him he was going to kill his former girlfriend, Teresa Hausler, when she returned to their apartment to pick up her belongings. Scuderi immediately saw Joseph for an emergency therapy session, during which Joseph again threatened to kill Hausler if he found her at the apartment.

Joseph refused voluntary hospitalization, and after consulting with others at the facility, Scuderi concluded that Joseph did not meet the requirements for involuntary commitment under the MHPA.<sup>31</sup> After assuring his therapist he was under control and would not harm Hausler, Joseph left the facility.

A few minutes later, Hausler, who was also a patient, called Scuderi and asked where Joseph was. Scuderi told Hausler not to go to the apartment and to return home instead. Hausler ignored the warning and went to the apartment where she encountered Joseph, who shot and killed her.

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26. Cal. Civ. Code §43.92 (2013).

27. By 2018, all but two states had weighed in on whether and how a *Tarasoff*-type duty applied to therapists in their jurisdictions. Only Maine and North Carolina had rejected *Tarasoff* completely, 15 states had adopted discretionary laws permitting therapists to breach confidentiality in a *Tarasoff*-type situation, and 32 states had imposed a mandatory duty on therapists judicially or statutorily permitting liability in the event of a breach. For a compilation of laws in every state, see NATIONAL CONFERENCE OF STATE LEGISLATORS, MENTAL HEALTH PROFESSIONALS' DUTY TO WARN (2018), <https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>.

28. Alan R. Felthaus, *Warning a Potential Victim of a Person's Dangerousness: Clinician's Duty or Victim's Right?* 34(3) J. Am. Acad. Psychiatry & L. 338 (2006).

29. In *Dunkle v. Food Service East, Inc.*, several months after his discharge from the hospital, a patient strangled his girlfriend to death. The Superior Court held that a therapist "owes no duty to warn or otherwise protect a non-patient where the patient has not threatened to inflict harm on a particular individual." 582 A.2d 1342, 1347 (Pa. Super. Ct. 1990). In *Leonard v. Latrobe Area Hospital*, the Superior Court dismissed a claim that a psychologist failed to warn a patient's wife of her husband's violent propensities, when the patient had been violent toward her previously. The court remarked that it was a "curious lapse in logic" for the plaintiffs to claim a therapist should have warned them of information they already had. 625 A.2d 1228, 1231 (Pa. Super. Ct. 1993).

30. 720 A.2d 1032 (Pa. 1998).

31. 50 P.S. §7301 (2021 P.P.).

The trial court dismissed all claims brought by Hausler's representative against Joseph's treatment providers on the pleadings. The Pennsylvania Superior Court affirmed the dismissal, agreeing that the therapists were immune from suit for failing to commit Joseph absent gross negligence or willful misconduct as provided by the MHPA.<sup>32</sup> On the claim that the defendants negligently failed to protect Hausler, the Superior Court noted that Pennsylvania had not adopted a *Tarasoff*-like duty, but even if such a duty existed, it was discharged when Scuderi instructed Hausler not to return to the apartment.

The Pennsylvania Supreme Court granted allocatur, limited to the questions of "whether a mental health professional has a duty to warn a third party of a patient's threat to harm the third party [and] if there is a duty to warn, the scope thereof. . ."<sup>33</sup>

After acknowledging that it had not yet ruled on the issue, the Court surveyed other jurisdictions and concluded, "the concept of a duty to protect by warning, albeit limited in certain circumstances, has met with virtually universal approval."<sup>34</sup>

The Court recognized the opposing arguments, including the difficulty of predicting violent behavior,<sup>35</sup> the importance of safeguarding therapist/patient confidentiality, and the Commonwealth's policy of treating patients in the least restrictive environment,<sup>36</sup> but concluded that the imposition of a duty was, after all, a policy decision, and in this situation, the societal interest in protecting citizens from harm outweighed the countervailing concerns.<sup>37</sup>

Finding that therapists owe a duty to warn third parties, the Court proceeded to delineate the circumstances under which that duty would arise:

First, the predicate for a duty to warn is the existence of a specific and immediate threat of serious bodily injury that has been communicated to the professional. We believe that in light of the relationship between a mental health professional and patient, a relationship in which often vague and imprecise threats are made by an agitated patient as a routine part of the relationship, that only in those situations in which a specific and immediate threat is communicated can a duty to warn be recognized.

Moreover, the duty to warn will only arise where the threat is made against a specifically identified or readily identifiable victim. Strong reasons support the determination that the duty to warn must have some limits. We are cognizant of the fact that the nature of therapy encourages patients to profess threats of violence, few of which are acted upon. Public disclosure of every generalized threat would vitiate the therapist's efforts to build a trusting relationship necessary for progress. Moreover, as a practical matter, a mental health care professional would have great difficulty in warning the public at large of a threat against an unidentified person. Even if possible, warnings to the general public would "produce a cacophony of warnings that by reason of their sheer volume would add little to the effective protection of the public."<sup>38</sup>

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32. 50 P.S. §7114 (2001).

33. 720 A.2d at 1034.

34. *Id.* at 1037.

35. The Court rejected the research offered on this point, stating: "[W]e are unpersuaded that difficulty in predicting violent conduct alone should justify barring recovery in all situations. The standard of care for mental health professionals adequately takes into account the difficult nature of the problem facing them. . . . We take note that mental health professionals are trained to detect, identify, evaluate and deal with threats and violent behavior, thus setting themselves apart from others who are faced with the knowledge of threats of violence against a third party. Thus, we reject Appellees' argument that a duty to warn should not be recognized because of some difficulty in determining violent behavior." *Id.* at 1039.

36. *Id.* at 1041.

37. *Id.*

38. *Id.* at 1040-1041, quoting *Thompson v. County of Alameda*, 614 P.2d 728, 735 (Cal. 1980).



Applying the new rule, the Court found Joseph's threat was specific, immediate, and directed against an identified individual, triggering the duty to warn. The Court found that, when Scuderi instructed Hausler not to go to the apartment but to return home instead, the therapist had sufficiently discharged his duty toward her.<sup>39</sup>

## VI. EXPANDING THE IDENTIFIABLE VICTIM: THE MAAS CASE

The *Emerich* rule stood undisturbed until 2020, when the Pennsylvania Supreme Court decided *Maas v. UPMC*.<sup>40</sup> The facts of the case are complex but vital for understanding the ruling and its implications.

Terrance Andrews, a patient with a history of severe mental illness, was treated by psychiatrist Michelle Barnwell, M.D., and received therapy and intensive case management services through the Western Psychiatric Institute and Clinic Adult Community Treatment Team (CTT).

In January 2008, CTT facilitated Andrews' move from assisted living to a private apartment on the fourth floor of Hampshire Hall, in the Oakland section of Pittsburgh. The building contained 20 apartments on each of four floors, for a total of 80 units.<sup>41</sup> Andrews continued to receive mental health services through CTT on an outpatient basis.

Andrews did not adapt well to independent living. He appeared in the emergency room repeatedly and was voluntarily hospitalized four times for a total of 65 days over a five-month period.

The Supreme Court noted that, between January and April, Andrews frequently expressed suicidal and homicidal ideations, and often complained to his treatment providers about his "neighbors" and others, including threatening to kill a neighbor who had been knocking on his door in the middle of the night. He reported several verbal run-ins with various neighbors, leading to his next-door neighbor's boyfriend hitting him with a baseball bat. The Court detailed each incident that occurred in May: on May 9, Andrews expressed homicidal ideation to the emergency room staff, including a plan to stab the "neighbor" with scissors, but he was allowed to leave; on May 10, Andrews threatened to harm an unnamed "next-door neighbor" and he was hospitalized briefly; on May 15, Andrews described a plan to kill his "next-door neighbor and everyone." The Court noted that Andrews did not identify any neighbor by name, and his treatment providers took no steps to warn any residents of the threats.<sup>42</sup>

On May 25, Andrews returned to the emergency room, claiming he had not taken his medication for three weeks, was hearing voices, and had suicidal and homicidal thoughts. According to the Court, "A case-manager at that facility dissuaded him from seeking admission and sent him home to his apartment with medication for agitation and a promise to secure him placement in a personal care home within 36 hours."<sup>43</sup> Various treatment providers had testified that, each time Andrews ex-

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39. The Court adopted a limited duty to warn, but "left for another day" the question of whether Pennsylvania would consider imposing upon therapists a broader "duty to protect" third parties as adopted in *Tarasoff*. *Id.* at 1037, n.5.

40. 234 A.3d 427 (Pa. 2020).

41. The Supreme Court erroneously reported that the building contained a total of 40 units. *Id.* at 429, n.1. According to the Pittsburgh Police Department's Initial Report, which was included in the record on appeal, the building is composed of four floors with 20 units on each. Transcript of Record at 450a, *Maas v. UPMC*, 234 A.3d 427 (Pa. 2020) (No. 7 WAP 2019).

42. 234 A.3d at 429-430.

43. *Id.* at 430.

pressed homicidal thoughts, he was questioned further, but he never identified anyone specifically.<sup>44</sup>

On May 29, 2008, Andrews murdered Lisa Maas, a 19-year-old culinary student, by stabbing her to death with scissors in her apartment, five doors away from his own. When he was arrested, Andrews said, “I told them the medication wasn’t working. I told people I was going to kill someone.” Andrews was later convicted of first-degree murder and sentenced to life in prison.<sup>45</sup>

Laura Maas sued Andrews’ treatment providers on behalf of her daughter, alleging he posed a danger to all residents of Hampshire Hall, particularly those on his floor, and his therapists negligently failed to warn the tenants of the danger he created.<sup>46</sup> The parties agreed that Andrews had never specifically threatened Lisa Mass, and that he had never mentioned any encounter with her to his therapists. The defendants moved for summary judgment, claiming Lisa Maas was not a reasonably identifiable target of Andrews’ threats, and, therefore, they had no duty to warn her.

The trial court, relying heavily on the Vermont case of *Kuligoski v. Brattleboro Retreat*,<sup>47</sup> determined that, although no threats were made against the decedent, as a “neighbor” residing on the same floor as Andrews, she was “within the zone of danger” of individuals who might be harmed.<sup>48</sup>

The Superior Court did not adopt the “zone of danger” rule but agreed that Lisa Maas, because she lived on the same floor as Andrews, was a readily identifiable victim under *Emerich*. The court determined Andrews’ therapists could be held liable for failing to issue warnings to the residents of the other 19 units on the fourth floor of Hampshire Hall.<sup>49</sup>

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44. The record cited by the parties includes the following additional details not specifically included in the Supreme Court’s discussion: On January 14, 2008, Andrews expressed thoughts of killing himself, a neighbor, and “others in general who piss me off.” He also said he would “go across the street and kill someone just to go to jail where I can get the death penalty and die.” He was voluntarily hospitalized for 14 days. On March 5, he expressed homicidal ideation toward “others” and “people on the street.” He was voluntarily hospitalized for one month. On April 5, he expressed suicidal ideation. On examination, he admitted to homicidal thoughts against his brother and his friends. He was admitted to the hospital voluntarily for 14 days. On May 1, he appeared at the emergency room, angry he had not received his social security check, and expressed homicidal ideation “towards anybody” stating he wanted to stab someone with a knife. On May 9, Andrews appeared at the emergency room, expressing homicidal thoughts about a male neighbor, saying he planned to stab him with scissors. On further examination, he identified the man as his next-door neighbor’s boyfriend who had broken his arm with a baseball bat. (Andrews did not have a broken arm.) On May 10, he again appeared at the emergency room saying he was not homicidal, but he had earlier wanted to kill someone he had an altercation with. He was admitted to the hospital voluntarily where he stayed for three days. Each time Andrews was hospitalized, he was not discharged until his suicidal and homicidal ideations had resolved. On May 18, Andrews appeared at the emergency room, angry that he had been fired from a job on his first day, and saying he wanted to “eat pills” and kill his “next-door neighbor and anyone else.” He stated that he “walks around town with scissors” but no scissors were found in his possession. On May 25, he appeared at the emergency room, said he had been off his medications, was suicidal, and wanted to “hurt other people.” His case manager began the process of arranging to return him to assisted living. At 5 p.m. on May 29, Andrews called the CTT office. The record of the call noted that he was in a “pleasant mood.” At 10:30 p.m. that night, Andrews stabbed Lisa Maas in her apartment five doors down the hall. Brief for Petitioners, UPMC Presbyterian Shadyside, et al. 10-20, Maas v. UPMC, 234 A.3d 427 (Pa. 2020) (No. 7 WAP 2019).

45. 234 A.3d at 430.

46. *Id.*

47. 156 A.3d 436 (Vt. 2016)

48. Maas v. UPMC, No. GD 09-18900 slip op. at 6 (Allegheny Co. Nov. 9, 2016), citing *Kuligoski*, 156 A.3d at 459.

49. Maas v. UPMC, 192 A.3d 1139 (Pa. Super. Ct. 2018). In the months preceding the murder, Andrews threatened specific individuals (his “next-door neighbor’s boyfriend,” the neighbor who knocked on his door, his brother, his friends) and made general threats against others (people on the street, someone

The Supreme Court framed the issue on appeal: “[F]or purposes of determining if appellants had a duty to warn Lisa Maas, we consider whether a ‘moment’s reflection’ by appellants would have sufficed to readily identify Andrews’s unnamed neighbor-victim as a Hampshire Hall resident, and whether imposing a duty to warn under such circumstances is warranted.”<sup>50</sup>

The Court reviewed the *Emerich* decision, noting that “the circumstances in which a duty to warn a third party arises are extremely limited,”<sup>51</sup> and only triggered when a patient “communicate[s] a ‘specific and immediate threat’ against ‘a specifically identified or readily identifiable victim.’”<sup>52</sup> The Court observed that *Emerich* did not “define what factors might coalesce to ascertain, or aid in determining whether or when an unnamed victim is readily identifiable,” but pointed to *Thompson* as an example of threats issued to the public at large that would not give rise to a duty to warn.<sup>53</sup>

The *Maas* Court distinguished *Thompson*, agreeing that there, the patient’s threat to kill “a child in the neighborhood” was directed toward a “large and amorphous group” to which the child-victim who lived a few doors away from the patient belonged, and to whom no duty was owed. Differentiating between a child who lived down the street and a woman who lived down the hall, the Court pointed to evidence that Andrews had been stressed by his living situation, and that he had communicated homicidal ideation toward “neighbors” on several occasions. The Court held that Andrews’ potential targets were readily identifiable as “members of a specific group—in this case ‘neighbors’ residing in the patient’s apartment building.”<sup>54</sup> The Court concluded that the plaintiff had established a *prima facie* case that the therapists had breached a duty to warn Lisa Maas and affirmed the denial of summary judgment.

The dissenting justices were persuaded that Andrews’ threats were insufficiently specific to give rise to a duty to warn Lisa Maas. Significantly, they noted the discrepancy between those the trial court and Superior Court identified as entitled to warning, and those identified by the Supreme Court:

The lower courts deemed the readily identifiable group as the fourth-floor tenants of Hampshire Hall, while the Majority concludes that all tenants of the building were members of the readily identifiable group to which a duty to warn was owed. *These disparate interpretations of the term “neighbor” suggest that the term is not, in fact, readily identifiable.*<sup>55</sup>

The dissent asserted that, in weighing the competing interests, when a threat is made against the general community, the balance tips toward protecting confidentiality. “[I]f each ideation of a mental health patient is broadcast to a large segment of society, that patient would be ostracized from the very community that he or she

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across the street, and “everyone”). Although he never threatened other fourth-floor residents, the Superior Court identified the geographical limit of Andrews’ threats, foreseeable to his therapists, as encompassing the residents of the fourth floor, and excluding residents of other three floors, the rest of the complex, and the surrounding neighborhood. *Id.* at 1148.

50. 234 A.3d 437, citing *Tarasoff*, 551 P.2d at 345, n.11.

51. *Id.* at 438, quoting *Emerich*, 720 A.2d at 1040.

52. *Id.*

53. *Id.*

54. 234 A.3d at 439. The majority was apparently not persuaded that requiring a warning issued to every resident of Hampshire Hall each time Andrews expressed homicidal thoughts against his “neighbors” would be impractical, and would produce the “cacophony of warnings that by reason of their sheer volume would add little to the effective protection of the public” that prompted the *Emerich* Court to limit the scope of therapists’ duty to warn. *Emerich*, 720 A.2d at 1040-1041.

55. 234 A.3d at 440, n.1 (Baer, J. dissenting) (emphasis added).

seeks to join and the bond of trust between the patient and mental health professional would be broken.”<sup>56</sup>

## VII. IMPLICATIONS AND POSSIBLE SOLUTIONS

It seems clear that Andrews required a more structured treatment setting, and the Court was no doubt frustrated that his therapists did not, or could not, facilitate that change before tragedy struck.<sup>57</sup> The Court’s desire to avoid sending the family of an innocent victim away without relief is commendable, but it did so by contorting the now-entrenched duty to warn so that its scope could be discernable to therapists only in hindsight. The decision circumvents the policy encouraging treatment in the least restrictive environment by punishing therapists for failing to issue warnings to anyone who may encounter the patient within that environment. As pointed out by the dissent:

[T]reatment of the mentally ill is not an exact science. If we allow recovery against mental health . . . providers for harm caused by their patients, except in the clearest of circumstances, we would paralyze a sector of society that performs a valuable service to those in need of mental health care.<sup>58</sup>

The Pennsylvania legislature, in seeking to protect the rights of those with mental illness, made a clear policy choice: the least restrictive setting consistent with effective treatment is always preferred. By providing immunity to therapists who act in good faith to further that policy, the legislature signaled its intent to shield treatment providers from liability for unfortunate outcomes. To guard against the negative impact the *Maas* decision will likely have on therapists’ treatment decisions in furtherance of that policy, Pennsylvania can look to other states that have addressed the issue legislatively.<sup>59</sup>

As many states have done, the Pennsylvania legislature can statutorily define the therapist’s duty, specifically delineate those to whom a duty is owed, and set forth the specific actions the therapist can take to discharge that duty.<sup>60</sup> Some states have adopted the suggestion of the *Tarasoff* dissent, allowing liability only where the therapist makes the clinical assessment that the patient is likely to carry out violent threats.<sup>61</sup> Still other states extend immunity from liability except under explicitly defined circumstances, whether the therapist breaches confidentiality and issues a warning or makes the judgment not to do so.<sup>62</sup> To encourage effective treatment of those with serious mental illness, Pennsylvania could extend qualified immunity to therapists who act in good faith in determining whether to issue a warning or maintain confidentiality.

Finally, and perhaps most important, a society that values both the rights of people with disabilities and public safety must invest sufficient resources in treatment options available to those with serious mental illnesses, which historically has not

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56. *Id.* at 443.

57. At various points, the record reflects Andrews’ case manager was seeking an open bed in an assisted living facility. It appears that such arrangements were imminent at the time of the murder. *Id.* at 430. The Supreme Court noted: “On more than one occasion, in response to [his] requests, Andrews was told his return to supported living would be arranged, but it was not.” *Id.* at 429, n.2.

58. *Id.* at 443, (Baer, J. dissenting) (quoting *F.D.P. v. Ferrara*, 804 A.2d 1221, 1232 (Pa. Super. Ct. 2002)).

59. See *supra* note 27 compilation of state laws.

60. See, e.g., Cal. Civ. Code §43.92 (2013).

61. See, e.g., Fla. Stat. §491.0147 (2009).

62. See, e.g., Ind.Code §34-30-16-1 (1998); Mass.Gen.Laws Ann. Ch. 123 §36B (1999).

occurred.<sup>63</sup> Placing the burden of protecting society upon therapists will not compensate for a lack of accessible care and, indeed, may further exclude those most in need from effective treatment and, ultimately, diminish the security and well-being of the community.

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63. For a comprehensive examination of the persistent insufficiency of resources for treatment of those with serious mental illness, *see*: D.J. JAFFE, *INSANE CONSEQUENCES: HOW THE MENTAL HEALTH INDUSTRY FAILS THE MENTALLY ILL* (Amherst, New York, Prometheus Books 2017).