Testimony to Senate Committee on Judiciary
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First, I would like to thank those who have sponsored S.3 to address this important issue. The case at the center of the Kuligoski decision is tragic for all concerned and this testimony is not meant to diminish that tragedy in any way.

As an Executive Director who has also worked for 30 years in the field of mental health, primarily in residential and emergency services outreach to people experiencing mental health crisis, I read the Kuligoski decision both from a clinical eye and as an administrator, who is responsible for the provision of treatment and supports, as well as the liability of an entire Agency of human services workers – 750 people working with up to 7000 people every year, those people experiencing some real hardships and trauma in their lives. As I delved into the decision, I realized a couple of things: 1) I am going to have to phone my attorney a lot; and 2) I need to think of the overlay of this ruling on multiple scenarios and play out what I would do differently.

The primary concerns that came to mind were the elements of privacy and confidentiality that would be eroded by predicting uncertain futures through disclosures to "caregivers", who are not legally bound to the individual, or to those within a "zone of danger", a zone we as providers would have to determine. As we implement that disclosure over time, we will also be messaging clients we serve that we are a dangerous system to share information with and, in the long run, our communities may become less safe because people will not voluntarily seek help from those who will inform on a series of predictors which might apply to any of us in a stressful situation.

While there is no correlation between people with schizophrenia and violence, the Kuligoski decision made me question whether the court was drawing one. We have to ask, "how does it impact the perceptions people have of this diagnosis being attached to violence and what responsibilities do people who provide support and treatment have to assign themselves to in order to comply with the law when working with people with this diagnosis?" I can guarantee you that it gravely impacts the work we do every day in trying to reduce stigma.

Let me give you a real life example which accentuated for me the implications around violation of privacy, stigma, and external pressures added to the delivery system, all in one fell swoop if I apply the Kuligoski decision --- while not enhancing safety in any fashion.

We actually have several group home/recovery residences in which Washington County Mental Health Services is involved. People come to us out of the hospital and sometimes on what we call an Order of Non Hospitalization, which is essentially a community committal process outlining conditions upon which the person is discharged from the hospital to live in the community. Some people who have an ONH have had at least one episode in their past of an escalation where they may have expressed a desire to harm themselves or others, may have thrown something, pushed someone, or hit someone.

Mental anguish is no different than physical anguish. When someone is experiencing severe physical pain, they may writhe. When someone is experiencing extreme mental anguish, they may also have increased motor movement that can be perceived or interpreted as “assaultive”.

So back to our real life residential, we recently had a person leave one of our homes without permission. This person’s ONH says they should reside at the home and follow treatment. The manner in which the person left was definitely something we would call an elopement. It was obvious the exit was strategic. While having no reason to believe there was, on the surface, a danger, the person had an assaultive episode in his past. This led me, as a provider, to start to question: “what is the zone of danger”? Do we go knocking on doors in the neighborhood at this hour?

In implementing our response protocol, the person was located within an hour, off site, and the emergency services team was phoned to meet the police to offer identification. An emergency exam was written to place the person in the hospital, primarily because of the violation of the ONH, and this was through an assessment by a psychiatrist and qualified mental health professional. The EE was not upheld by a judge during a preliminary hearing and the person was returned home. When you consider that we, as a system, have written more EEs this year than ever in the past, the impact of this ruling on that front end process is certainly called into question.

Due to the police response, this occurrence was also published in the paper with information on the person’s background, which caused our residents in the home to talk amongst themselves and with our staff about what they heard. What this then raised was that 3-4 other people in the residential home had some episode of escalation in their past. Should we be disclosing/informing on these other people , who I would clearly argue would be in a zone of danger – living in the same house. If I knew that was going to happen to me, I would not go there to live.

The fact is we cannot always predict future violence; but if there is a true emergency and imminent risk or threat, we approach individuals or authorities and make those disclosures as the law currently requires. It is my position that our current laws allow us the protections we need and this ruling pigeon holes people with mental illness in a way that Peck and Tarasoff do not. I am hoping we can peel back this ruling to duty to warn as outlined in the Peck decision.

Thank you!