NAMI Vermont
National Alliance on Mental Illness

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NAMI Vermont
January 27, 2017
Committee: Senate Judiciary Committee
Re: S.3 Duty to Warn

Chairman Sears and Committee Members, thank you for inviting NAMI Vermont to testify today on bill S.3.

I am the Executive Director of the National Alliance on Mental Illness of Vermont (NAMI Vermont). NAMI Vermont is the independent Vermont chapter of the National Alliance on Mental Illness, a statewide non-profit, grassroots, volunteer organization comprised of family members, friends, and individuals affected by mental illness. As our mission, NAMI Vermont supports, educates and advocates so that all communities, families, and individuals affected by mental illness or mental health challenges can build better lives.

In Vermont, 1 in 5 people experience a mental illness - that's approximately 25,000 individuals plus their family and loved ones. One in 20 adults lives with serious mental illness such as schizophrenia, major depression or bipolar disorder.

NAMI Vermont is concerned that the Vermont Supreme Court Kuligoski decision establishes such a broad and imprecise duty to warn of potential danger to a third party that providers will either be reluctant to work with patients who could present such a liability to them or will hold patients longer than they would otherwise.

There are also other concerns. The language as written in S.3 is stigmatizing and targeting the duty to warn only to mental health professionals. The rest of the professional community who may be in contact with other populations that may be violent and dangerous should be considered. The public needs to be protected from all individuals who may be an imminent danger to an identifiable victim not just people with mental illness.

We would like to address the impact of establishing liability in the Duty to Warn. Caregivers are very concerned about the lack of psychiatrists that are available in Vermont. Many primary care doctors are taking on the role of prescribing psychiatric medicine. The question we need to ask is whether the Kuligoski ruling will discourage psychiatrists and other clinicians from practicing in Vermont.

NAMI strongly advocates that people with mental illness not be stigmatized and subjected to discrimination by being labeled "violent." A person with a severe mental illness, without substance abuse issues, has the same chances of being violent as any other person, without substance abuse issues, in the general population.[1]

Under Kuligoski, the expectation to require providers to educate and advise caregivers about the risks that they may encounter goes beyond the scope of their responsibility as a mental health

care provider. Training someone to understand the complexities of mental illness is not something that can be done in the limited amount of time that providers can give caregivers. Does this then shift the liability onto the caregiver because they were warned or trained to give the right care?

It is important to note that among the services that NAMI Vermont offers is an evidence-based 12-week Family-to-Family education program specifically for family members, partners and significant others of individuals with mental illness. The course covers information about the major mental illnesses; coping skills such as handling crisis and relapse; basic information about medications; listening and communication techniques; problem-solving skills; recovery and rehabilitation; and self-care for the caregiver. Over 300,000 participants have graduated from this national program.

NAMI's definition of a family caregiver is someone giving emotional, financial or practical support to a person with a mental health condition.[2] This could include parents, adult children, spouses, family members, neighbors, and/or friends.

Even the best education cannot help us to predict when someone might become a danger to others. As caregivers, one of our primary concerns is whether our loved one will be a danger to themselves. In Vermont, there are 80 suicides annually. Suicide is the eighth leading cause of death in Vermont. This is higher than the number of motor vehicle deaths or homicides in Vermont. The vast majority of those who die by suicide live with mental illness - often undiagnosed or untreated.

When a minor is living with a mental health condition, parents are key participants in decisions about treatment, special education services and meeting their child's needs. However, once an individual is 18, we can only support our loved one and encourage them to get the help they need, adhere to taking their medication, or attend appointments. We cannot force them to do anything they do not want to do. We experience the heartbreak of seeing our loved one's mental health deteriorate and cannot help them until they become a danger to themselves or others. A caregiver and the individual with the mental illness are put at great risk because help isn't available until a dangerous situation develops. For example, individuals in mental health crisis who visit an emergency room, are often times turned away until it is articulated that a plan is in place to die by suicide. As caregivers, our families are not new to knowing how mental illness can affect our loved one. We know the seriousness of what it is like to not receive consistent treatment.

There is widespread agreement in the mental health community that most people with mental illness are not violent. The best way to reduce the risk of the very small subset of individuals who pose an increased risk of violence is through treatment. However, an individual with a mental health condition who believes that participating in mental health treatment could subject him or herself to the possibility of legal implications will not seek treatment. They rely on a trusting relationship with their provider. Breaking confidentiality could create barriers to the willingness of individuals to seek treatment. Fewer than one-third of adults and one-half of children with a diagnosed mental health condition receive mental health services.[3]

There are statutes that are in place to ensure that if a person is a danger to self or others, they will get treatment – this may be voluntary or involuntary. As caregivers, we want our loved ones to recover in the least restrictive environment. We don't want them to be a danger to themselves or

others. We rely on providers to use the right judgement and their standards of care. If a situation escalates to the point of needing to exercise a Duty to Warn, we would hope that further treatment will continue for that person who is a danger to him or herself or others.

The recent increase in wait time in emergency departments for someone requiring acute level care has been alarming. There needs to be a different and better solution to the boarding of patients in the ER. Many NAMI Vermont members have reported waits of 10-14 days before they are able to get a bed and receive treatment. Could the Kuligoski ruling be contributing to the lack of availability of beds when providers are in fear of releasing those who are ready to return to the next level of care? More attention and different solutions need to be done. A stakeholder group has formed recently that will begin to address these issues. When solutions will be proposed, we urge lawmakers to take action.

Thank you for your attention and listening to our comments.

1. Elbogen & Johnson, The Intricate Link Between Violence and Mental Disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions, 66 Arch. Gen. Psychiatry 911, 914 (2005), at 915.
2. NAMI website: https://www.nami.org/Find-Support/Family-Members-and-Caregivers
3. U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, Md., U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services,1999, pp. 408-409, 411.