The Honorable John Barker
Committee of Federal and State Affairs
Statehouse Room 346-S
Topeka, KS 66612

Subject: HB2308 - Suicide evaluation upon admission to certain treatment facilities.

Thank you, Chairman Barker and members of the committee for allowing me to speak in support of HB2308. My name is Kim Perry.

You know, the older we get our memory seems to fade. Things are not always as clear as they once were. However, there is a day that no matter the length of time that passes will never be erased from my memory. January 13th, 2002. This is the day I lost my husband, my little girl's father. His name is Gordon "Gordy" Peterson. He was pushing his 32nd birthday at the time. In the years prior to his death he struggled with many addictions including alcohol, marijuana & later prescription pills which namely lead him to his unfortunate death. His pill of choice was Xanax, which was prescribed originally for anxiety. At an earlier age, Gordon was diagnosed with ADD (Attention Deficit Disorder) which he carried throughout his adult years. Having an addictive personality this prescription quickly became a habit that he used excessively. Close to a week before his death Gordon made the decision to take himself off the Xanax. This escalated quickly for him. Unknowing of the side effects from withdraw of the Xanax, Gordon began to hallucinate & become unable to tell "real from not real". On January 11th, 2002 he was taken to the ER for hallucinating where they did a tele video with a psychologist for evaluation. He was later released. The following morning, January 12th, 2002 he woke up determined to make some changes, get help & get well. He spent the better part of the morning researching treatment facilities & having a wellness check to make sure he was physically capable of withstanding a treatment program. The later part of the day he finally decided to check in at Parallax in Wichita, KS. He was scared, hopeful & ready to get well. After gathering his things, he drove himself to check in at 5:30 p.m. that evening. It was my understanding we wouldn't be able to speak to him for a few days while he settled in & began his treatment. I was wrong, so wrong. I would never have the chance to speak to him again.

On the morning of Sunday January 13th, 2002 I received a call from Gordon's sister saying my mother in law had seen a police car at our house. I proceeded to call the Augusta, KS Police Dept. where I was quickly directed to the Wichita Police Dept. regarding the visit to our home. Once on the phone with the officer I was informed that Gordon was deceased. No how, why, when, NOTHING! I was then told to be at Parallax to retrieve his belongings later that morning. I was only met by a "counselor". My husband's belongings were brought to me in a black trash bag where they proceeded to check them in front of me. Remember, at this time I still have no information regarding the cause of his death. I was told I would have to meet with the Director of the facility the next morning. This appointment turned into 2:30 p.m. the following day. I went an entire day before I knew the cause of my husband's death. Why would this be concealed? What happened? What do I tell my daughters? At the time Abbey Peterson was 3 years old & Emily Peterson just 1.5 years old. So many things went through my head, even I couldn't understand this as an adult how would I explain this to my girls?

Finally a meeting with the Director of Parallax. "Your husband has committed suicide". No caring, no compassion, no concern as I was told. She bluntly informs me that "it was her feeling that he intended to do this upon check in". How does something like this happen in such a facility? My husband went there for help, to get well. I knew this had to be a mistake. But it wasn't. Upon questioning, I found out that by "suicide" she meant he had hung himself. He had taken a shoe string & hung himself. His first attempt failed. There were 2 attendants that heard a loud noise from his room & went to check on him sometime in the night only to find him setting on his bed. They asked if he was alright, he said "I'm fine". His second attempt worked. The attendants went to wake him for breakfast & did not see him in the room. After checking the room, as they were leaving they found him hanging in the closet.

This still shocks me. After 16 years I'm still in disbelief that this was able to happen in a treatment facility. People need to understand that someone who is entering a facility for any such reason or as Gordon was, they're giving up their life for the time being. Anything & everything that is familiar to them, their family, a job, income, even their home. They're entrusting this facility to help lead them to the path of wellness.

Even though this happened to me, my girls & family, Gordon is the real victim. The disservice was done to him by lack of “service” or “watch” so to speak. I’ve always felt like he was just checked in to do his time there. Immediate help for recovery should have begun the minute he entered the facility. For 16 years now I’ve raised my girls alone without their father. I’ve watched them compete without their father. I’ve watched them achieve without their father. I’ve watched them suffer without their father. I’ve watched them live without their father.

My hope for this bill is to change the way a person is evaluated upon entering any facility no matter if it is State or Privately owned & monitored in the days to follow. Let’s set forth with this opportunity to help make changes so no one else has to lose or live without a loved one.

Kim Perry