

Senate Health & Welfare Committee
Senate bill 226 – Assisted Outpatient Treatment
October 2, 2007

My name is Tanya Feliz. I am a psychiatric social worker and currently serve as the Director of a Supportive Case management Outreach Team (SCOT) in Bucks County. I am extremely grateful for the opportunity to address this committee today regarding the issue of Assisted Outpatient Treatment. I am here today as an advocate for SB 226.

For the past fifteen years, I have worked with and advocated for people with severe and persistent mental illness. Four of those years were spent working on an Assertive Community Treatment Team in Brooklyn, New York where I worked with individuals whose needs had not been met by traditional forms of social services. I worked with clients who had histories that included multiple local and state hospitalizations, poor follow up with outpatient services, poor adherence to their medication regimen and some who became violent under such circumstances. I lived and worked in New York at the time that Kendra Webdale was pushed in front of a NYC subway by Andrew Goldstein, a man with a well documented history of dangerousness during periods when he was not adhering to his treatment regimen. On any given day that could have been a client that was served by my team. I also lived and worked in New York when Kendra's Law was signed by then Governor George Pataki. During the four years that I worked with the ACT Team, I requested numerous AOT orders and testified in numerous court hearings but I have also advocated that less restrictive methods be tried first and requested that numerous clients be discharged from court orders that were no longer necessary due to progress made by clients. I believe strongly that Assisted Outpatient Treatment works! I've seen Assisted Outpatient Treatment work. I am reminded of a young man (who I'll call Thomas) that I worked with on the ACT Team. Thomas was 18 years old when I met him. He had a diagnosis of paranoid schizophrenia, had been hospitalized 12 times for symptoms associated with this diagnosis, had been arrested 2 times for

random assaults and had the police called to his home well over 20 times for assaulting family members – or domestic disputes as they were logged by the police. He had a history of not taking his medication as prescribed, if he took them at all, and was often aggressive and violent when he did not. Thomas was one of the first clients who received an AOT order on my ACT Team and one of the first clients who I testified in favor of receiving a court order. Thomas hated me for a long time and there were times that I felt that my own safety was in jeopardy. Our team stuck with him – this young man who only wanted nothing more than to be “normal.” He didn’t want to take medication, see a psychiatrist, attend a psychosocial program or have a team of people come out to his home. He did not realize that his disorder could be treated and that such treatment could dramatically change both quality and the course of his life, put an end to or at least limit the number of hospitalizations, quiet the voices, control the impulse to hurt and ultimately give him the thing that he wanted most – to be “normal.” There were many ups and downs in my working relationship with Thomas. There were a few more hospitalizations after the AOT order was signed but eventually Thomas began receiving treatment and I hear is doing well. When I began working with Thomas I was his case manager at some later point I became his social worker and by the time I left the ACT Team I had served as the Program Director for two years. When I decided to relocate to Pennsylvania and learned that my staff and the clients we served would have a farewell gathering for me, I wondered if Thomas would attend. He did. I remember seeing him at the gathering and he said, “You know Ms. Tanya, I used to think that you got promoted because of the number of times you hospitalized me. Now I know you were on my side the whole time. Thank you Ms. Tanya. I’m going to miss you.” About 8 months after leaving New York, I heard from a former co-worker who informed me that Thomas was graduating from a Peer Specialist Training Program and wanted me to attend his graduation. When he saw me he ran up to the registration table, grabbed one of those “Hello My Name Is...” tags and on it wrote NORMAL. Thomas now works as a Peer Specialist on an Assisted Outpatient Treatment Team.

I am not convinced that Thomas would be where he is today without the Assisted Outpatient Treatment program because I feel that Thomas is one of a small number of clients who needs mandated treatment long enough to recognize that he had an illness, that there is effective treatment and that his life could be altered in ways that perhaps he had not imagined. This is the value of Assisted Outpatient Treatment. It works because in the (temporary) mandating of treatment, clients are able to experience an existence when their symptoms do not consume a major portion of their day thus increasing the likelihood of educational, vocational, and social connections – things that are important to all of us and things that normalize our lives. AOT has been proven to reduce the number of psychiatric hospitalizations. AOT has been proven to reduce arrest and incarceration rates for individuals served. This is crucial if one is be able to function in and contribute to their individual community and society as a whole. Studies show that connecting mental health clients with a job and suitable and affordable housing help move them along their path to recovery. For some clients the difference between having and AOT order and not having one is incarceration. This is not an acceptable alternative!

I would like to end by discussing families. Having reviewed the agenda and the number of family members scheduled to speak to this committee today, I would be remiss if I didn't discuss the effects of mental illness and violence on the family system. While cases like Kendra Webdale and Virginia Tech shooting – random acts of violence – often make the headlines it is often family members and friends who are most likely to be the recipient of aggressive behavior or violence. These acts of violence are no more an acceptable form of violence than a person with a mental illness pushing a stranger in front of a subway. Family members are often put in the impossible dilemma of becoming a victim of violence or having a loved one arrested and sent to jail. Assisted Outpatient Treatment offers another option and it would be irresponsible for us not to utilize it.

I thank the committee for allowing me to testify in support of SB 226, for its attention to this issue and for your recognition of the need to implement a system that allows people with severe and persistent mental illness to be closely monitored to make sure they receive the treatment that they need and deserve.