

Testimony: Senate Bill 226
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I appreciate this opportunity to offer some comments on Senate Bill 226 regarding Assisted Outpatient Treatment of persons with mental illness.

I have been a long time advocate of persons with mental illness and their families. I have also worked in our mental health system for many years, in various administrative capacities including case management, partial hospital, residential and crisis residential and long term care planning. I am also a former foster parent of a child with mental health concerns who in his late adolescence committed a heinous crime for which he is now serving a life sentence in one of our Pennsylvania state correctional facilities. I come to this hearing in each of these capacities and am speaking only for myself on my personal views. I have had the opportunity, however, to gain experience with local, state and national perspectives on issues concerning mental illness and accessing treatment when needed, and I am bringing those perspectives here today as well.

I have no doubt that there exists a condition in up to as many as 50% of persons with serious mental illness known as anosognosia, or lack of insight that the symptoms such as auditory hallucinations and delusions are occurring. There is no question that one of the symptoms of mental illness, for many persons with these disorders, is a lack of recognition that anything is wrong or in fact needs to be addressed so that the individual may resume a more satisfactory lifestyle. I also know for a fact that there continues to

persist in our society a terrible stigma towards mental illness, which frequently prevents people from seeking help and families from wanting to acknowledge that someone they know and love could be stricken by one of these conditions. I also have no doubt that as a society we are largely uneducated about these disorders, and uncomfortable with interacting with someone with mental illness (even when they are our own family member). We see something is wrong and we feel increasingly uncomfortable with it. We feel alarmed, confused, and sometimes frustrated and sometimes frightened. What can we do, and who can we turn to for help?

All of us here are probably familiar with our current commitment law for in-patient treatment, which states that someone has to present a clear and present danger to themselves or someone else to meet criteria. We can all agree that this is inadequate and prevents many who need help from getting it. I believe we can also agree that we need to change those criteria, so people can get help sooner and not have to wait until they do something dangerous. Some here may know about our current out-patient commitment law – yes, we do have one, and for the past 10 years or so it has been largely unreliable. Why? Mainly because there is no way to follow through with the ultimatum of returning someone to the state hospital if treatment is not obtained.

Would Senate Bill 226 change this? Would it guarantee that county officials would put in place methods to monitor compliance? If funding were provided and services were in place and case managers- and- ACT- teams-and- out-patient- facilities- with- psychiatrists- on-site to- provide- treatment- as- required-when –required- and- within-

given- framework -of- time-mandated - and- in-patient- beds -were-available-
immediately - on -demand- when- the individual- is- not-compliant -with-their -court-
ordered out-patient treatment ----- S 226 expects a lot from the current system
that already has proven it cannot enforce what it is already mandated to. I have been
In the system long enough, as a foster parent, a provider and as an advocate, to question
whether the funding would be put in place to allow for all that S 226 mandates. And I
question why we would not put that same funding and energy into compassionate ways
of engaging people, educating them about their illness and guiding them towards
whatever form of treatment works for them.

Senate Bill 226 allows for the police to pick individuals up for their hearing if they do
not come voluntarily, or if they do not comply with treatment. I have been involved with
police training at Montgomery County Emergency Services for the past 3 years or so, and
I was a co-presenter in August of our MCES police school and pre- and post booking jail
diversion program at the third annual CIT conference in Memphis, Tennessee. I've met a
lot of officers across the country who have been trained to handle emergencies involving
persons with mental illness. I know that these trainings are voluntary, and these officers,
whether they go out in teams or individually, are on that call because they are trained and
are interested in addressing these situations in a humane and caring way. I also know that
when an officer picks someone up and takes them into custody, that person must be
handcuffed with their hands behind their back, placed in the back of the police car and
taken to their destiny. I wonder how and why our police officers, who only signed on to
protect society, have suddenly become our social workers? I wonder why we are placing

untrained officers into situations that they are not familiar with, in which they may need to respond and may choose the wrong response? I further wonder why persons who are probably experiencing delusions, paranoia, auditory hallucinations must be confronted by uniformed officers who are very visibly carrying weapons are brought to "treatment" in such a manner that would scare anyone more than it would force them into "compliance". I wonder why we continue to discriminate (and yes stigmatize) against persons with mental illness who are refusing treatment when we do not do the same for a person with a heart condition who continues to smoke, or a person with diabetes who continues to ignore their dietary needs? Why are we showing society and our legislators that this is the best and the only way to treat people with mental illness? I know we have better ways and can do a much better job than what we are proposing here to do.

I thank you for your time.