S.287 Public Comment
Michael Sabourin

Hello, Michael Sabourin, Marshfield, VT., I'm a family member, mental health advocate, and work for Vermont Psychiatric Survivors as a psychiatric resident advocate
I want to start by saying that involuntary medication is a violent act in itself that doesn't decrease injuries; frequently staff and patients are injured in the process
I fear that, combining the commitment and involuntary medication hearings will practically make involuntary medication synonymous with admission. In current statute an individual has to be committed before the state can file an order for involuntary medication. This results in involuntary medication applications totaling less then 10 % of the total commitment applications. In addition only about 5% of involuntary commitment applications ever make it to a judgement by court; with most cases reaching some form of settlement before the commitment hearing.
The thin veil of protection patients have with the current system will be lost with the proposed legislative changes. If simultaneous filings can occur they will likely happen all the time. After admission, seventy two hours, whatever; if you don't agree with what the doctors say they could just file for involuntary medication. There will be certainly less incentive of whatever incentive there was to work with patients; and patients on involuntary medication orders will likely increase precipitously.
Regarding eliminating the stay on court appeals; this would mean should you lose a hearing and want to appeal an adverse decision - you will still be subject to unwanted neuroleptics during the course of the appeal.
Should this bill pass we will have a mental health system of care predicated on involuntary treatment and coercion or more simply put predicated on violence.

There is nothing in the bill to insure that involuntary treatment will not increase. In current practice a majority of individuals acquiesce to treatment before their commitment hearing and then a certain number after if they loose their commitment hearing; all of these individuals will now be subject to involuntary medication applications.

Also S.287 seems to take in a number of misconceptions :

1.) that individuals not receiving medications are more violent then the general population. There is no statistical support for this and patients receiving or not receiving medication have a potential for violence.

2.) receiving involuntary medication will expedite the availability of beds. In current practice the greatest incentive to taking medication is not the medications themselves; but time. Individuals take medication because they want to get discharged, not because it necessarily makes them feel better. It should be remembered that individuals take up beds for all sorts of medical and legal reasons.

3.) that individuals refusing and receiving care do not have emotions, feelings or civil rights; that they are just diagnostic objects; or as some say "speaking diseases".

4.) that involuntary medication relieves someone's suffering. As someone said it may relieve the suffering of the watcher, but individuals have difficulty while on and off medication.

..... (end of oral testimony)

5.) that individuals refusing medication must be suffering from anosognosia. There is no statistical reason to embrace a mental health diagnosis. You will be lucky to find relief from your condition and in return you will be discriminated against, disenfranchised, unbelievable, unemployable, unheard, etc., etc.

It is an opinion that this bill and it's reliance on involuntary medications are a substitute for inadequate resources for staffing, space, and training to manage challenging patients.

The one possible right that the bill alludes to adding, a preliminary hearing. This is already available in current statute; they just don't inform you. In addition, this bill would restrict evidence to just the content of the filing papers; guaranteeing that no patient would ever win a preliminary hearing.

Thank you for considering my concerns,

Michael Sabourin
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