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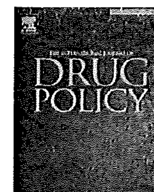

Editors' Choice

The effectiveness of compulsory drug treatment: A systematic review

D. Werb [a,b,*], A. Kamarulzaman [c], M.C. Meacham [b], C. Rafful [b], B. Fischer [d], S.A. Strathdee [b], E. Wood [a,b,e]

[a] International Centre for Science in Drug Policy, Li Ka Shing Knowledge Institute of St. Michael's Hospital, 30 Bond Street, Toronto, ON, Canada M5B 1W8
[b] Division of Global Public Health, Department of Medicine, University of California, San Diego, 9500 Gilman Drive, La Jolla, CA 92093-0507, USA
[c] Faculty of Medicine, University of Malaya, 50603 Kuala Lumpur, Malaysia
[d] Social & Epidemiological Research Unit, Centre for Addiction & Mental Health (CAMH), 33 Russell Street, Toronto, ON, Canada M5S 3B1
[e] Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS, 608-1081 Burrard Street, Vancouver, BC, Canada V6Z 1Y6

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ABSTRACT

Background: Despite widespread implementation of compulsory treatment modalities for drug dependence, there has been no systematic evaluation of the scientific evidence on the effectiveness of compulsory drug treatment.
Methods: We conducted a systematic review of studies assessing the outcomes of compulsory treatment. We conducted a search in duplicate of all relevant peer-reviewed scientific literature evaluating compulsory treatment modalities. The following academic databases were searched: PubMed, PAIS International, Proquest, PsycINFO, Web of Science, Soc Abstracts, JSTOR, EBSCO/Academic Search Complete, REDALYC, SciELO Brazil. We also searched the Internet, and article reference lists, from database inception to July 15th, 2015. Eligibility criteria are as follows: peer-reviewed scientific studies presenting original data. Primary outcome of interest was post-treatment drug use. Secondary outcome of interest was post-treatment criminal recidivism.
Results: Of an initial 430 potential studies identified, nine quantitative studies met the inclusion criteria. Studies evaluated compulsory treatment options including drug detention facilities, short (i.e., 21-day) and long-term (i.e., 6 months) inpatient treatment, community-based treatment, group-based outpatient treatment, and prison-based treatment. Three studies (33%) reported no significant impacts of compulsory treatment compared with control interventions. Two studies (22%) found equivocal results but did not compare against a control condition. Two studies (22%) observed negative impacts of compulsory treatment on criminal recidivism. Two studies (22%) observed positive impacts of compulsory inpatient treatment on criminal recidivism and drug use.
Conclusion: There is limited scientific literature evaluating compulsory drug treatment. Evidence does not, on the whole, suggest improved outcomes related to compulsory treatment approaches, with some studies suggesting potential harms. Given the potential for human rights abuses within compulsory treatment settings, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms.

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Background

Globally, dependence to illicit and off-label drugs remains a key source of morbidity and mortality, and is implicated in criminal recidivism. For instance, 1.7 million of the world's estimated 13 million people who inject drugs (PWID) are believed to be HIV-positive while more than 60% of PWID globally are estimated to be hepatitis C (HCV) positive (UNODC, 2015). Illicit drug dependence is also estimated to have contribute to 20.0 million disability-adjusted life years in 2010 (Degenhardt, Whiteford, & Ferrari, 2013) while, the United Nations Office on Drugs and Crime (UNODC) estimated that there were as many as 231,400 drug-related deaths in 2013, the majority of which were the result of drug overdoses (UNODC, 2015). Additionally, a UNODC review found that between 56% and 90% of PWID reported imprisonment since initiating injection drug use (Jurgens, 2007).

An increasing range of evidence-based treatment modalities have been found to be effective in improving outcomes from

* Corresponding author at: Division of Global Public Health, University of California San Diego, University of California School of Medicine, 9500 Gilman Drive, La Jolla, CA 92093-0507, USA.
E-mail address: dwerb@ucsd.edu (D. Werb).

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substance use disorder and attendant harms. For example, among individuals addicted to opioids, opioid substitution therapies (OST) including methadone and buprenorphine maintenance have been shown to reduce negative drug-related outcomes and to stabilize individuals suffering from opioid dependence (Amato, Davoli, Ferri, & Ali, 2002; Cowing, Ali, & White, 2004; Mattick, Breen, Kimber, & Davoli, 2009). In a recent review, use of Suboxone (a combination of buprenorphine and naloxone) was demonstrated to be effective for opioid withdrawal (As, Young, & Vieira, 2014; Ferri, Davoli, & Perucci, 2011; Krupitsky et al., 2011; Wolfe et al., 2011). Evidence of effectiveness for pharmacotherapies for stimulant use disorder remains mixed (Castells et al., 2010; Fischer, Blanken, & Da Silveira, 2015). However, a large set of psychosocial tools have shown promise for a range of substance use disorders (Dutra et al., 2008; Grabowski, Rhoades, & Schmitz, 2001; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Mooney et al., 2009; Prendergast, Podus, Finney, Greenwell, & Roll, 2006; Shearer, Wodak, Van Beek, Mattick, & Lewis, 2003).

In many settings, compulsory treatment modalities have been in place or are being implemented. For instance, a recent international review found that as of 2009, 69% of a sample of countries ($n = 104$) had criminals laws allowing for compulsory drug treatment (Israelsson & Gerdner, 2011). Compulsory drug treatment can be defined as the mandatory enrolment of individuals, who are often but not necessarily drug-dependent, in a drug treatment program (Wild, 1999). While most often consisting of forced inpatient treatment (i.e., individuals are placed under the care and supervision of treatment institutions), compulsory treatment can nevertheless be designed as outpatient treatment as well, either using an individualized treatment or group-based model that can include psychological assessment, medical consultation, and behavioral therapy to reduce substance use disorder (Hiller, Knight, Broome, & Simpson, 1996). Compulsory drug treatment (particularly in inpatient settings) is often abstinence-based, and it is generally nested within a broader criminal justice-oriented response to drug-related harms (WHO, 2009). Compulsory treatment is distinct from coerced treatment, wherein individuals are provided with a choice, however narrow, to avoid treatment (Bright & Martire, 2012). Perhaps the most widely known example of coerced treatment is the drug treatment court model, which provides individuals charged with a drug-related crime with therapeutic measures in addition to criminal justice interventions under the auspices of the criminal justice system (Werb et al., 2007). While no systematic evaluation of the effectiveness of compulsory treatment approaches has been undertaken, observers have cited concerns regarding human rights violations within compulsory drug treatment centers (Hall, Babor, & Edwards, 2012; Jurgens & Csete, 2012). Further, while overviews as well as reviews on related topics (i.e., quasi-compulsory treatment) exist (Stevens, Berto, & Heckmann, 2005; Wild, Roberts, & Cooper, 2002), no recent systematic assessments of the efficacy or effectiveness of compulsory or forced addiction treatment have been undertaken. This represents a critical gap in the literature given the implementation and scale up of compulsory treatment in a range of settings, including Southeast Asia, Latin America, and Australia.

Observers have also noted that while the overall number of countries that employ compulsory drug treatment approaches is declining, the mean duration of care is increasing, as is the number of cases of individuals sentenced to compulsory drug treatment (Israelsson & Gerdner, 2011). Relatedly, observers have expressed concern with evidence that compulsory treatment centers incorporate therapeutic approaches generally unsupported by scientific evidence, and employ punishment for individuals who relapse into drug use (Amon, Pearshouse, Cohen, & Schleifer, 2013; Hall & Carter, 2013; Pearshouse, 2009a). Given the need for scientific evidence to inform effective approaches to drug treatment, we therefore undertook a systematic review of the effectiveness of compulsory drug treatment.

Methods

We employed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for the development of systematic reviews (Moher, Liberati, Tetzlaff, & Altman, 2009). A full review protocol is available by request to the corresponding author.

Eligibility criteria

Studies were eligible if they were peer-reviewed, and if they evaluated the impact of compulsory drug treatment on illicit drug-related outcomes. The primary outcome of interest was defined as the frequency of post-treatment drug use. The secondary outcome of interest was defined as any post-treatment drug-related criminal recidivism (i.e., post-treatment arrest or incarceration). Randomized control trials (RCTs) and observational studies were both eligible for inclusion. To be eligible, treatment interventions reported had to be compulsory; however, the type of intervention (e.g., inpatient abstinence-based therapy, outpatient group therapy, OST, etc.) could vary. Reviews as well as multi-component studies that did not disaggregate findings between components were not eligible if they did not provide specific data regarding the impact of compulsory treatment. Studies that assessed mandated treatment for legal or licit substances (i.e., alcohol, tobacco) were also not eligible. Further, studies that only evaluated outcomes such as attitudinal or psychosocial change, or psychological functioning related to substance use were excluded. Finally, studies that evaluated coerced or quasi-compulsory treatment (i.e., wherein individuals are provided with a choice between treatment and a punitive outcome such as incarceration such as a drug treatment court model) were excluded.

Information sources

We searched the following 10 electronic databases: Pubmed, EBSCOhost/Academic Search Complete, Cochrane Central, PAIS International/Proquest, JSTOR, PsycINFO, Soc Abstracts, Web of Science, REDALYC (Spanish language) and Scielo Brazil (Portuguese language). We also searched the internet (Google, Google Scholar), relevant academic conference abstract lists, and scanned the references of potentially eligible studies.

Search

We searched all English-, Spanish- and Portuguese-language studies and abstracts and set no date limits. The following search terms were used: "forced treatment," "compulsory treatment," "substance abuse," "substance use," "mandated treatment," "mandatory treatment;" "addiction," "addiction treatment," "involuntary treatment," "involuntary addiction treatment." The terms were searched as keywords and mapped to database specific subject headings/controlled vocabulary terms when available, including MeSH terms for PubMed searches. Each database was searched from its inception to its most recent update as of June 15th, 2015.

Study selection

Two investigators (MM, CR) conducted the search independently and in duplicate using a predefined protocol. The investigators scanned all abstracts and obtained full texts of articles that potentially met the eligibility criteria. Validity was

assessed in duplicate based on eligibility criteria. After all potentially eligible studies were collected, three investigators met to achieve consensus by comparing the two review datasets (MM, CR, DW). Differences were reviewed by three investigators (MM, CR, DW) and a final decision to include or exclude was then made.

Data extraction process

Between September 10th, 2014 and June 15th, 2015, data were extracted using a standardized form soliciting data on study design, setting, sample size, participant characteristics, type of compulsory intervention, measures of effectiveness, and study quality. Given the variance in study methodologies and treatment interventions, we extracted a range of summary measures, including difference in means, risk ratio, and odds ratio. The data were then entered into an electronic database.

Risk of publication bias

Compulsory drug treatment centers have been implemented or brought to scale in a number of settings, including Vietnam, China, and Brazil. However, these settings produce disproportionately less academic scholarship than other settings such as established market economies. For this reason, there is a potential risk of publication bias that may result in a smaller number of peer-reviewed evaluations of compulsory treatment in settings in which these interventions are more widely implemented. This may, in turn, affect the publication of studies relevant to the present systematic review.

Additional analyses

Study quality was assessed using the Downs & Black criteria by two authors independently (MM, CR) (Downs & Black, 1998). This scale evaluates five domains: reporting, external validity, risk of bias, confounding, and statistical power.

Given the wide variance in intervention design and reported outcomes, it was not feasible to perform a meta-analysis of findings.

Role of the funding source and ethics approval

This study was supported by the Canadian Institutes of Health Research, Open Society Foundations, and the U.S. National Institute on Drug Abuse. At no point did any external funder play a role in the collection, analyses, or interpretation of data, writing of the manuscript or decision to publish. All authors had complete access to all data, and all had final responsibility to submit the manuscript for publication. No ethics approval was required for this review.

Results

Study selection and characteristics

Overall, as seen in Fig. 1, 430 studies were initially identified, of which 378 were excluded because they did not present primary and/or specific data on compulsory treatment. Of the remaining 52 studies, 17 were excluded because they constituted reviews or editorials, 18 were excluded because they did not focus on illicit drug use (i.e., they focused on alcohol treatment), and 8 studies were excluded because they evaluated quasi-compulsory treatment rather than compulsory treatment interventions. Nine studies met the inclusion criteria (combined $n = 10{,}699$). Three studies employed longitudinal observational approaches, four studies employed prospective case control designs, one study employed a cross-sectional design, and one study employed a quasi-experimental design. Six studies evaluated compulsory inpatient treatment or drug detention, one study evaluated prison/detention-based treatment, and two studies evaluated compulsory community-based treatment.

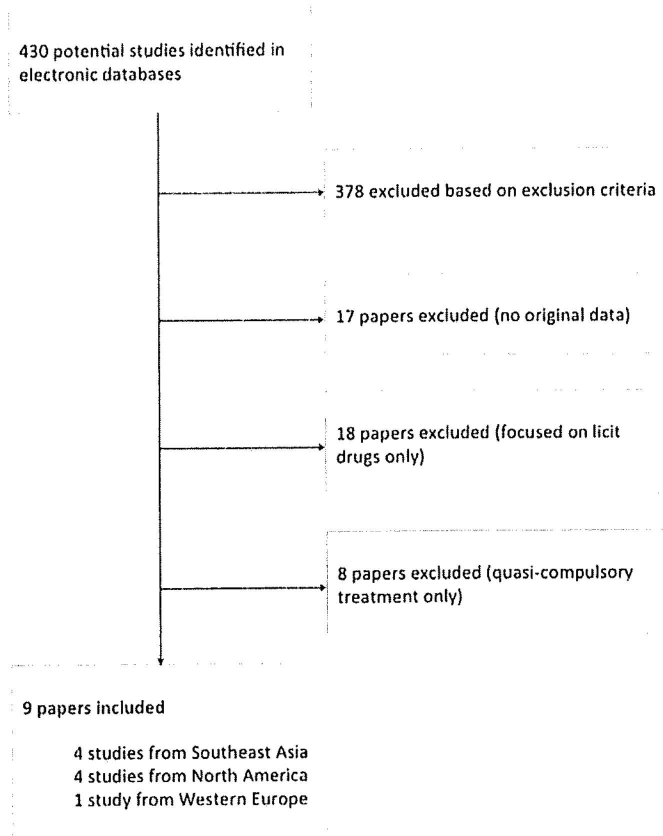

Fig. 1. Screening and study selection process.

Methodological quality assessment

The Downs & Black scale has a possible score of 0 to 18, with 18 being a perfect score (highest quality). The median score for eligible studies was 12 (interquartile range: 9.5–15). All studies failed to undertake adequate steps to mitigate all risk of bias; eight studies (89%) did not optimally address risk of confounding, and five studies (56%) did not report all relevant study characteristics, methods, or findings. One study (Sun, Ye, & Qin, 2001) (11%) was only available as an abstract.

Results of individual studies

Three studies reported no significant impacts of compulsory treatment on substance use compared with control interventions (Fairbairn, Hayashi, & Ti, 2014; Kelly, Finney, & Moos, 2005; Sun et al., 2001). Two studies found equivocal results but did not compare against a control condition (e.g., voluntary drug treatment) (Jansson, Hesse, & Fridell, 2008; Strauss & Falkin, 2001). Two studies observed negative impacts of compulsory treatment on criminal recidivism (Huang, Zhang, & Liu, 2011; Vaughn, Deng, & Lee, 2003). Two studies found positive outcomes: one study observed a small significant impact of compulsory inpatient treatment on criminal recidivism (Hiller, Knight, & Simpson, 2006), and a retrospective study found improved drug use outcomes within the first week of release after treatment (Strauss & Falkin, 2001).

Six studies evaluated compulsory inpatient treatment or drug detention (Fairbairn et al., 2014; Huang et al., 2011; Hiller et al., 2006; Jansson et al., 2008; Kelly et al., 2005; Sun et al., 2001). Huang et al. (2011) examined the impact of mandatory inpatient drug treatment on post-treatment drug use patterns over the period of a year among participants in Chongquing, China (nY= 177). As the authors note, Chinese police are given authority over mandatory drug treatment facilities, and have the power to detain individuals within these facilities for a period of weeks to several months (Huang et al., 2011). While the allocation of treatment varies by facility, treatment modalities commonly offered include "physical exercise, moral and legal education, drug and health education, and skill training (e.g., computer skills)" (Huang et al., 2011). The authors do not, however, provide specific data on the content of any of these activities. The authors did not specify what type of treatment participants received, referring only to treatment and counseling. However, 46% of respondents reported using illicit drugs within a month to six months after release from mandatory treatment; a further 10% relapsed within one year (Table 1).

Sun et al. (2001) compared relapse into drug use among a sample of heroin users in China (nY= 615) enrolled in mandatory detoxification, volunteer detoxification, and detoxification with 're-education through labor' (i.e., compulsory drug detention). Overall relapse within a year among the sample was 98%; 22% relapsed within three days, and 52% relapsed within one month. There was no significant difference between rates of relapse between sample participants enrolled in mandatory detoxification, volunteer detoxification, or detoxification in a compulsory drug detention center (Sun et al., 2001).

Hiller et al. (2006) investigated the impact of a mandated six-month residential addiction treatment intervention on post-treatment criminal recidivism. Participants in Dallas, Texas (nY= 506) were mandated to participate in a modified therapeutic community (TC), defined as addiction treatment provided within a controlled environment within which supervision is maximized (Hiller et al., 2006). All participants were probationers or individuals arrested for drug-related crimes in Dallas county. Three groups were compared: a graduate group (nY= 290; participants who successfully completed six months of the TC treatment process), a dropout group (nY= 116; participants who failed to complete six months within the TC), and a comparison group (nY= 100) comprised of a random sample of probationers from the Dallas county probationers list. The authors then compared the 1-year and 2-year incarceration rates across the three comparison groups, and found no significant differences after 1-year across all three groups (20% of the dropout group, 17% of the graduate group, and 13% of the comparison group were re-arrested and incarcerated; pY> 0.05). The proportion of participants incarcerated within 2 years did not differ significantly between the graduate and comparison groups (21% vs. 23%, pY> 0.05), though the dropout group had a significantly higher proportion of participants incarcerated compared with the other two groups (30%, pY< 0.05) (Hiller et al., 2006).

Jansson et al. (2008) investigated the long-term impact of compulsory residential care among drug-using individuals in Sweden (nY= 132). This included supervision and care from psychologists, a psychiatrist, nurses, social workers, and treatment attendants. Across 642 observation years after compulsory residential care, 232 observation years (37%) included a criminal justice record, despite the fact that all participants were assigned to treatment (Jansson et al., 2008). Further, in a longitudinal multivariate analysis, use of opiates was significantly associated with subsequent criminal recidivism.

A five-year longitudinal study compared treatment outcomes among American veterans across 15 Veterans Affairs Medical Centers in the United States (nY= 2095) who either had justice system involvement and were voluntarily enrolled in treatment (JSI); were mandated by the justice system to receive treatment (JSI-M); or had no involvement in the justice system and were enrolled in treatment (No-JSI) (Kelly et al., 2005). The treatment provided was an abstinence-based, 12-step program (Ouimette, Finney, & Moos, 1997). Kelly et al. (2005) compared one- and five-year substance use and criminal recidivism outcomes among participants in each group and adjusted for a range of socio-demographic and dependence-related variables. The authors noted that the JSI-M (mandated) group had a significantly lower-risk clinical profile compared with the comparison groups at baseline, which necessitated adjustment via the multivariate analyses. After one year, participants in the JSI-M group had the highest reported level of abstinence from illicit drugs (61.0%), significantly higher than the JSI or No-JSI groups (48.1% vs. 43.8%, respectively) (Kelly et al., 2005). However, after five years no significant differences in the proportion of those in remission from drug use were detected across groups (JSI-M = 45.4%; JSI = 49.8%; No-JSI = 46.4%) (Kelly et al., 2005). With respect to criminal recidivism, the JSI group reported a significantly higher proportion of individuals rearrested (32.3%) compared with the JSI-M or No-JSI groups (20.6% vs. 18.3%, respectively, pY> 0.05). There were no significant differences in the proportion of participants rearrested after five years (JSI-M = 23.6%; JSI = 32.3%; No-JSI = 18.3%). The authors concluded that, while JSI-M participants had a more favourable clinical profile at baseline, they did not have significantly improved therapeutic gains compared with the other groups after five years (Kelly et al., 2005).

Fairbairn et al. (2014) sought to determine whether detainment in a compulsory drug detention was associated with subsequent cessation of injection drug use among a sample of PWID in Bangkok (nY= 422). Thailand has a large system of compulsory drug detention centers that seeks to promote drug abstinence through punishment, physical labor, and training among individuals charged with drug possession and other minor drug crimes (Fairbairn et al., 2014). Generally, detainees undergo a 45 day assessment period, followed by four months of detention and two months of vocational training (Pearshouse, 2009b). The authors found that 50% of participants reported a period of injection cessation of at least one year (i.e., 'long term cessation'). In multivariate logistic regression analysis, incarceration and voluntary drug treatment were both associated with long-term cessation, though compulsory drug detention was only associated with short-term cessation (i.e., ceasing injection drug use for less than a year) and subsequent relapse into injecting (Fairbairn et al., 2014). The authors concluded that strategies to promote long-term cessation are required to address ongoing relapse among Thai PWID (Fairbairn et al., 2014).

One study evaluated mandatory prison-based addiction treatment. Vaughn et al. (2003) evaluated Taiwan's compulsory prison-based addiction treatment program. This program, implemented in 1997, required individuals arrested for illicit drug use to undergo a one-month detoxification regime upon incarceration. At that point, a medical doctor determined whether offenders were drug dependent; such individuals were then sentenced to 12 months in prison and enrolment in a three-month drug use treatment program. The treatment was abstinence-based and included physical labor, psychological counseling, career planning, religious meditation, and civil education (no further details regarding the content of the psychological counseling, career planning, and civil education was provided by study authors). If offenders did not satisfactorily complete the program, they were forced to repeat it until successful completion (Vaughn et al., 2003). Once released, individuals were required to pay the cost of treatment. The authors employed a quasi-experimental design wherein individuals who

Table 1
Results of systematic review of studies evaluating compulsory drug treatment approaches.

Author/ year	Location	n	Study period	Study design	Participant characteristics				Intervention	Changes in substance use	Changes in recidivism	Summary of outcomes	Quality score
					Mean age (range)	Female	Ethnicity	Drug use					
Sun et al. (2001)	China	615	NR	Cross-sectional	NR	NR	NR	NR	Mandatory detoxification vs. volunteer detoxification vs. Detoxification and compulsory drug detention	98% relapsed within one year	NR	Almost all participants relapsed within a year. No significant difference between participants enrolled in different interventions	8
Huang et al. (2011)	Chongqing, China	177	2009	Longitudinal observational	16% 18–25; 43.4% 26–35; 31.4% 36–45; 9.1% 46+	21.6%	Asian (Chinese)	87.5% alcohol; 69.4% heroin; 62.8% meth; 40.7% Manguo	Mandatory inpatient treatment	10.3% relapsed in less than a month; 35.5% 1–6 months; 10.3% 7–12 months; 43.9% ≥13 months	N/A	65% placed in mandatory treatment by police in past 12 months; 46% used drugs within 6 months of their release and 10% relapsed in 7–12 months	8
Rengifo and Stemen (2010)	Kansas	1494; 4359 in control group	2001–2005	Prospective case control	SB 123 group: 14–25 = 38.9% 26–35 = 28.2% >35 = 32.9% Control groups: >35 = 33.0–45.0%	SB 123: 29% Control groups: 19.3–26.5%	SB 123 group: 81.6% white Control groups: 75.5–78.2% white	NR	18 months of mandatory community based drug treatment	NA	No difference in recidivism	No significant impact on recidivism compared to community corrections; increase compared to court services	15
Fairbairn et al. (2014)	Bangkok, Thailand	422	N/A	Cross-sectional observational	38 (34–48)	18%	100% Thai	Heroin, methamphetamine, midazolam; proportions not reported	Compulsory drug detention vs. voluntary addiction treatment vs. MMT	Voluntary addiction treatment associated with sustained cessation; compulsory drug detention associated with short-term cessation	N/A	Compulsory drug detention not associated with long-term cessation	16
Jansson et al. (2008)	Sweden	132	Treated between 1997 and 2000; 5 year follow up	Longitudinal observational	Youth: 18.7 (16–20), Adults: 26.7 (18–43)	100%	NR	NR	Compulsory residential care	NA	Of 642 observation years, 232 (37%) contained a criminal justice record.	Recidivism was associated with use of opiates	12
Hiller et al. (2006)	Dallas, TX	506	1997–1999	Longitudinal observational	32.2 (SD: 9.2)	30%	10% Hispanic	NR	Mandated residential 6-month treatment	N/A	No significant differences in 1-year arrest rates. Significantly fewer graduates arrested in 2nd year than dropouts.	Treatment graduates slightly less likely to be arrested within 2 years of leaving the program	13

Table 1 (*Continued*)

Author/year	Location	n	Study period	Study design	Participant characteristics				Intervention	Changes in substance use	Changes in recidivism	Summary of outcomes	Quality score
					Mean age (range)	Female	Ethnicity	Drug use					
Kelly et al. (2005)	US	2095	5 year follow up (dates not reported)	Prospective case control	JSI-M = 42 (9.4) JSI = 40.7 (8.0) None = 42.9 (9.2) ($p < 0.01$)	None	49% African American; 45% White; 6% other	JSI-M: 44.7%; JSI: 58.3%; None: 57.5% ($p = 0.01$)	21- or 28-day SUD residential treatment programs from Veterans Affairs	1-year remission: JSI-M 61.0%; JSI 48.1%; None 43.8%; ($p < 0.01$) 5-year remission: JSI-M 45.4%; JSI 49.8%; None 46.4%; ($p = 0.32$)	1-year rearrest: JSI-M 20.6%; JSI 32.3%; Other 18.3%; ($p < 0.05$) 5-year rearrested: JSI-M 23.6%; JSI 27.7%; None 19.0%; ($p = 0.24$)	Mandated patients had less severe clinical profile at treatment intake; no differences in therapeutic gains during treatment.	15
Vaughn et al. (2003)	Taiwan	700	1999–2000	Quasi-experimental	NR	25% of 700 pre-release interviews	Asian	NR	Compulsory prison based treatment for drug using offenders	Treatment sample: 44% amphetamine, 26.6% heroin; Non-treatment sample: 9.1% amphetamine, 7.1% heroin	33% of treatment sample reincarcerated, 5% of non-treatment reincarcerated	Treatment group had worse outcomes than non-treatment group	11
Strauss and Falkin (2001)	Oregon	165	1995–1999	Prospective case control	ASAP: 30.9 VOA: 34.0	100%	African American: ASAP = 25–29.7% VOA = 13.8–20.5%	NR	Community based treatment programs	45 used drugs in first week after treatment (27%), 120 did not	NA	Those not using drugs in first week after mandated treatment more likely to have been in treatment longer and had individual and group support	11

Note: NA, not applicable; NR, not reported; SD, standard deviation; Meth, methamphetamine; MMT, methadone maintenance therapy; SB 123, Kansas' mandatory drug treatment policy; QCT, quasi-compulsory treatment; JSI, justice system involved individuals; JSI-M, justice system involved and mandated individuals; SUD, substance use disorder; ASAP, ASAP treatment services, Inc; VOA, volunteers of America residential program.

undertook the three-month drug treatment program (n_Y= 109) were compared with individuals who were not enrolled in the program as a result of being incarcerated prior to the program's implementation (n_Y= 99). Individuals were interviewed during pre-release and after 12 months of release from prison. Multivariate logistic regression analyses were used to identify any significant differences in post-treatment drug use and criminal recidivism. The authors found that offenders enrolled in the mandatory prison-based drug treatment program were significantly more likely to engage in post-release drug use and criminal recidivism. As such, they concluded that Taiwan's mandatory drug treatment system requires reform (Vaughn et al., 2003).

Two studies evaluated mandatory outpatient or community-based treatment. Strauss and Falkin (2001) sought to determine the short-term impact of a compulsory community-based treatment intervention on substance use among a sample of drug-using female offenders in Portland, Oregon (n_Y= 165). Participants were mandated to receive either treatment from 'ASAP' (Alcohol and Substance Abuse Prevention Program) or VOA (Volunteers of America). Both programs are community-based treatment interventions that include both mandated and voluntary clients, and are intended to last six months. ASAP is an outpatient program that employs an abstinence-based approach with individual counseling sessions and therapeutic group sessions (Strauss & Falkin, 2001) while VOA provides a residential program focused on the therapeutic community model, with an emphasis on structured activities, individual counseling, and building skills to reduce domestic violence and abuse risk (Strauss & Falkin, 2001). In a retrospective analysis focused on the first week after release from treatment, the authors found that women offenders who were in treatment longer were less likely to use drugs within the first week (Strauss & Falkin, 2001).

In 2003, the American state of Kansas implemented SB 123, a state senate bill legislating mandatory community-based treatment of up to 18 months for nonviolent offenders convicted of a first or second offense of drug possession (Rengifo & Stemen, 2010). Rengifo and colleagues compared criminal recidivism among individuals convicted of drug possession who were mandated to treatment (n_Y= 1494) vs. those on regular probation, sent to court services, or sent to prison (n_Y= 4359), though they do not describe the community-based treatment that individuals received. Data were collected between 2001 and 2005. Findings suggested that there was no significant impact on criminal recidivism among participants mandated to treatment compared to those mandated to regular probation. Of concern, participants mandated to treatment had a significantly increased risk of criminal recidivism compared to participants mandated to court services. The authors concluded that offenders mandated to treatment were not recidivating at a lower rate compared with offenders in alternative programs (Rengifo & Stemen, 2010).

Conclusion

Summary of evidence

While a limited literature exists, the majority of studies (78%) evaluating compulsory treatment failed to detect any significant positive impacts on drug use or criminal recidivism over other approaches, with two studies (22%) detecting negative impacts of compulsory treatment on criminal recidivism compared with control arms. Further, only two studies (22%) observed a significant impact of long-term compulsory inpatient treatment on criminal recidivism: one reported a small effect size on recidivism after two years, and one found a lower risk of drug use within one week of release from compulsory treatment (Strauss & Falkin, 2001). As such, and in light of evidence regarding the potential for human rights violations within compulsory treatment settings, the results of this systematic review do not, on the whole, suggest improved outcomes in reducing drug use and criminal recidivism among drug-dependent individuals enrolled in compulsory treatment approaches, with some studies suggesting potential harms.

These results are of high relevance given the reliance on compulsory drug detention among policymakers in a range of settings. Indeed, compulsory drug treatment approaches have been implemented in southeast Asia (Amon et al., 2013; Pearshouse, 2009b), the Russian Federation (Utyasheva, 2007), North America (Rengifo & Stemen, 2010), Latin America (CNN, 2010; Malta & Beyrer, 2013; Mendelevich, 2011; Utyasheva, 2007), Europe (Jansson et al., 2008), Australia (Birgden & Grant, 2010), and elsewhere (Israelsson & Gerdner, 2011). However, experts have noted that little evidence exists to support compulsory treatment modalities, and that the onus is therefore on advocates of such approaches to provide scientific evidence that compulsory treatment is effective, safe, and ethical (Hall & Carter, 2013). The results of the present systematic review, which fails to find sufficient evidence that compulsory drug treatment approaches are effective, appears to further confirm these statements (Hall et al., 2012). Human rights violations reported at compulsory drug detention centers include forced labour, physical and sexual abuse, and being held for up to five years without a clinical determination of drug dependence (Amon et al., 2013; Hall et al., 2012; Pearshouse, 2009a, 2009b). Governments should therefore seek alternative, evidence-based policies to address drug dependence.

The evidence presented herein also supports the joint statement on drug detention centers released by a range of United Nations-affiliated institutions declaring that, "[t]here is no evidence that these centres represent a favorable or effective environment for the treatment of drug dependence", and that "United Nations entities call on States to close compulsory drug detention and rehabilitation centres and implement voluntary, evidence-informed and rights-based health and social services in the community" (ILO, 2012). It is noteworthy in this regard that, while compulsory approaches appear ineffective, evidence suggests that a large body of scientific evidence supports the effectiveness of voluntary biomedical approaches such as OST in reducing drug-related harms (Amato et al., 2002; Mattick et al., 2009). China, Vietnam and Malaysia, for example, all previously scaled up compulsory drug detention centers, but are increasingly moving towards voluntary methadone maintenance and needle and syringe distribution systems to reduce the risk of blood-borne disease transmission from PWID sharing injecting equipment (Baharom, Hassan, Ali, & Shah, 2012; Hammett, Wu, & Duc, 2008; Nguyen, Nguyen, Pham, Vu, & Mulvey, 2012; Qian, Hao, & Ruan, 2008; Reid, Kamarulzaman, & Sran, 2007; Sullivan & Wu, 2007; Wu, Sullivan, Wang, Rotheram-Borus, & Detels, 2007). Emerging evidence suggests that expanded OST dispensation in these settings has been effective in reducing drug use (Baharom et al., 2012; Hammett et al., 2008; Nguyen et al., 2012; Yin, Hao, & Sun, 2010). This scale up of evidence-based biomedical and harm reduction interventions is occurring despite China's previous investment in a compulsory treatment infrastructure; as such, tensions remain between voluntary, public health-oriented approaches and compulsory detainment (Larney & Dolan, 2010), as they do in settings that include both compulsory and voluntary approaches, such as Mexico (Garcia, 2015; Lozano-Verduzco, Marín-Navarrete, Romero-Mendoza, & Tena-Suck, 2015). This may result in suboptimal treatment outcomes given that ongoing interactions with law enforcement and the threat of detainment within compulsory drug detention centers may cause drug-dependent individuals to avoid harm reduction services or engage in risky drug-using behaviors out of a fear of being targeted by police (Larney & Dolan, 2010), as has been observed in a range of settings (Bluthenthal, Kral, Lorvick, & Watters, 1997; Beletsky, Lozada, &

Gaines, 2013; Beletsky et al., 2014; Cooper, Moore, Gruskin, & Krieger, 2005; Werb, Wood, & Small, 2008). We also note that this is likely the case in settings seeking to control the harms of non-opioid substance use disorders such as cocaine use disorder, given that available interventions that have been shown to be effective have been undertaken using voluntary treatment approaches (Castells et al., 2010; Fischer et al., 2015; Hofmann et al., 2012). Governments seeking to implement or bring to scale harm reduction interventions that include OST and needle and syringe distribution will therefore likely be required to reduce their reliance on compulsory and law enforcement-based approaches in order to ensure treatment effectiveness.

Limitations

This systematic review has limitations. Primarily, risk of publication bias is present given political support for law enforcement-oriented strategies to controlling drug-related harms, particularly in Southeast Asia, where compulsory drug detention centers have been implemented by many national governments (Amon et al., 2013; Pearshouse, 2009b). In certain settings, such as Thailand, the scale up of drug detention centers has been accompanied by high-profile 'war on drugs' campaigns promoting enforcement- and military-based responses to drug harms (Fairbairn et al., 2014). Within such political climates, undertaking or publishing peer-reviewed research critical of compulsory drug treatment may be disincentivized. Further, while drug detention centers are more numerous in southeast Asia, this region has a limited infrastructure for scientific research on drug use, which may also increase the risk of publication bias.

Conclusions

Based on the available peer-reviewed scientific literature, there is little evidence that compulsory drug treatment is effective in promoting abstention from drug use or in reducing criminal recidivism. It is noteworthy that this systematic review includes evaluations of not only drug detention centers, but of a range of compulsory inpatient and outpatient treatment approaches. Additionally, the reductions in drug use and criminal recidivism as a result of compulsory drug treatment interventions were generally short-term or of low clinical significance. In light of the lack of evidence suggesting that compulsory drug treatment is effective, policymakers should seek to implement evidence-based, voluntary treatment modalities in order to reduce the harms of drug use.

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DW had full access to all the data in the study and had final responsibility for the decision to submit for publication. MM and CR conducted the systematic search, with assistance from DW. DW drafted the manuscript. EW provided guidance on the systematic review and meta-analysis methodology. BF, AK, SS, and EW revised the manuscript substantially. All authors have seen and approved the final version.

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Compulsory community and involuntary outpatient treatment for people with severe mental disorders

Cochrane Systematic Review - **Intervention** | Version published: 17 March 2017 see what's new

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Steve R Kisely | Leslie A Campbell | Richard O'Reilly
View authors' declarations of interest

Abstract *available in* English | Français

Background

It is controversial whether compulsory community treatment (CCT) for people with severe mental illness (SMI) reduces health service use, or improves clinical outcome and social functioning.

Objectives

To examine the effectiveness of compulsory community treatment (CCT) for people with severe mental illness (SMI).

Search methods

We searched the Cochrane Schizophrenia Group's Study-Based Register of Trials (2003, 2008, 2012, 8 November 2013, 3 June 2016). We obtained all references of identified studies and contacted authors where necessary.

Selection criteria

compulsory comm. tx.

All relevant randomised controlled clinical trials (RCTs) of CCT compared with standard care for people with SMI (mainly schizophrenia and schizophrenia-like disorders, bipolar disorder, or depression with psychotic features). Standard care could be voluntary treatment in the community or another pre-existing form of CCT such as supervised discharge.

Data collection and analysis

Authors independently selected studies, assessed their quality and extracted data. We used Cochrane's tool for assessing risk of bias. For binary outcomes, we calculated a fixed-effect risk ratio (RR), its 95% confidence interval (95% CI) and, where possible, the number needed to treat for an additional beneficial outcome (NNTB). For continuous outcomes, we calculated a fixed-effect mean difference (MD) and its 95% CI. We used the GRADE approach to create 'Summary of findings' tables for key outcomes and assessed the risk of bias of these findings.

Main results

The review included three studies (n = 749). Two were based in the USA and one in England. The English study had the least bias, meeting three out of the seven criteria of Cochrane's tool for assessing risk of bias. The two other studies met only one criterion, the majority being rated unclear.

Two trials from the USA (n = 416) compared court-ordered 'outpatient commitment' (OPC) with entirely voluntary community treatment. There were no significant differences between OPC and voluntary treatment by 11 to 12 months in any of the main health service or participant level outcome indices: service use - readmission to hospital (2 RCTs, n= 416, RR 0.98, 95% CI 0.79 to 1.21, low-quality evidence); service use - compliance with medication (2 RCTs, n = 416, RR 0.99, 95% CI 0.83 to 1.19, low-quality evidence); social functioning - arrested at least once (2 RCTs, n = 416, RR 0.97, 95% CI 0.62 to 1.52, low-quality evidence); social functioning - homelessness (2 RCTs, n = 416, RR 0.67, 95% CI 0.39 to 1.15, low-quality evidence); or satisfaction with care - perceived coercion (2 RCTs, n = 416, RR 1.36, 95% CI 0.97 to 1.89, low-quality evidence). However, one trial found the risk of victimisation decreased with OPC (1 RCT, n = 264, RR 0.50, 95% CI 0.31 to 0.80, low-quality evidence).

The other RCT compared community treatment orders (CTOs) with less intensive and briefer supervised discharge (Section 17) in England. The study found no difference between the two groups for either the main health service outcomes including readmission to hospital by 12 months (1 RCT, n = 333, RR 0.99, 95% CI 0.74 to 1.32, moderate-quality evidence), or any of the participant level outcomes. The lack of any difference between the two groups persisted at 36 months' follow-up.

Combining the results of all three trials did not alter these results. For instance, participants on any form of CCT were no less likely to be readmitted than participants in the control groups whether on entirely voluntary treatment or subject to intermittent supervised discharge (3 RCTs, n = 749, RR for readmission to hospital by 12 months 0.98, 95% CI 0.82 to 1.16 moderate-quality evidence). In terms of NNTB, it would take 142 orders to prevent one readmission. There was no clear difference between groups for perceived coercion by 12 months (3 RCTs, n = 645, RR 1.30, 95% CI 0.98 to 1.71, moderate-quality evidence).

There were no data for adverse effects.

Authors' conclusions

These review data show CCT results in no clear difference in service use, social functioning or quality of life compared with voluntary care or brief supervised discharge. People receiving CCT were, however, less likely to be victims of violent or non-violent crime. It is unclear whether this benefit is due to the intensity of treatment or its compulsory nature. Short periods of conditional leave may be as effective (or non-effective) as formal compulsory treatment in the community. Evaluation of a wide range of outcomes should be considered when this legislation is introduced. However, conclusions are based on three relatively small trials, with high or unclear risk of blinding bias, and low- to moderate-quality evidence. In addition, clinical trials may not fully reflect the potential benefits of this complex intervention.

→ No clear evidence to suggest effectiveness of involutary meantal heath tx

Plain language summary ↳

available in English | Français | Hrvatski | Polski | Русский

Compulsory community and involuntary outpatient treatment for people with severe mental disorders

Background

Many countries use compulsory community treatment (CCT) for people with severe mental health problems, including Australia, Canada, Israel, New Zealand, the UK, and the US. Supporters of this approach suggest that CCT is necessary due to the shift to community care of people with severe mental illness and that it is less restrictive to compulsorily treat someone in the community than to subject them to repeated hospital admissions. They also argue that it is effective in bringing stability to the lives of people with severe mental illness. Opponents of CCT fear treatment and support will be replaced by a greater emphasis on control, restraint and threat. There is also a fear that CCT may undermine the relationship between healthcare professionals and patients, leading to feelings of mistrust and being controlled, which may drive people with severe mental illnesses away from care services.

Given the widespread use of such powers, which compel people to follow-up with mental health services and undergo treatment while living in the community, it is important to assess the benefits, effectiveness or possible hazards of compulsory treatment.

Searches

This review is based on searches run in 2012 and 2013, and updated in 2016.

Study characteristics

This review now includes three trials with 749 people, with follow-up in one study extending to 36 months. Two of these trials compared forms of CCT versus standard care or voluntary care and the third trial compared a form of CCT called 'community treatment order' to supervised discharge.

Results

Results from the trials showed overall CCT was no more likely to result in better service use, social functioning, mental state or quality of life compared with standard 'voluntary' care. People in the trial receiving CCT were less likely to be victims of violent or non-violent crime. Short periods of conditional leave may be as effective (or non-effective) as compulsory treatment in the community.

Conclusions

There was very limited information available, all results were based on three relatively small trials of low to medium quality, making it difficult to draw firm conclusions, so further research into the effects of different types of CCT is much needed.

- Harvard Health Blog - https://www.health.harvard.edu/blog -

Involuntary treatment for substance use disorder: A misguided response to the opioid crisis

Posted By Leo Beletsky, JD, MPH On January 24, 2018 @ 10:30 am In Addiction,Health | Comments Disabled

Recently, Massachusetts Governor Charlie Baker introduced "An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention" (CARE Act) as part of a larger legislative package to tackle the state's opioid crisis. The proposal would expand on the state's existing involuntary commitment law, building on an already deeply-troubled system. Baker's proposal is part of a misguided national trend to use involuntary commitment or other coercive treatment mechanisms to address the country's opioid crisis.

The CARE Act and involuntary hold

Right now, Section 35 of Massachusetts General Law chapter 123 authorizes the state to involuntarily commit someone with an alcohol or substance use disorder for up to 90 days. The legal standards and procedures for commitment are broad; a police officer, physician, or family member of an individual whose substance use presents the "likelihood of serious harm" can petition the court.

Upon reviewing a petition, the court can issue a warrant for the arrest of the person with substance use disorder. The individual — who is not charged with a crime — is held pending an examination by a court-appointed clinician. The statute mandates that the determination proceed at a rapid pace, making it difficult to mount a meaningful defense.

The CARE Act proposes to further accelerate this process. The proposal would allow clinical professionals — including physicians, psychiatric nurses, psychologists, and social workers (or police officers when clinicians are not available) — to transport a person to a substance use treatment facility when the patient presents a likelihood of serious harm due to addiction and the patient will not agree to "voluntary treatment." Upon determination by a physician that the failure to treat the person would create "a likelihood of serious harm," the treatment facility has 72 hours to get the person to agree to voluntary treatment. If the person refuses, but the facility superintendent determines that discontinuing treatment would again cause "a likelihood of serious harm," the facility must petition the court for involuntary treatment under the process outlined in Section 35.

The expanded use of these laws

Laws that allow the state to commit people for substance use disorder are not new. The number of states with such laws went from 18 in 1991 to 38 jurisdictions, and counting. Existing laws vary significantly in the specific criteria for commitment, length, and type of treatment, if any is provided. The use of this mechanism has rapidly expanded as the opioid crisis has worsened; Massachusetts, with a population of under 7 million, committed a shockingly high number — more than 6,500 individuals — in 2016. Ironically, this expansion has occurred in conjunction with calls to move away from a criminal justice and toward a public health approach to the crisis, including a more concerted emphasis on treatment for people with addiction. But this well-intentioned shift carries little meaning when coercion and institutionalization are involved. In fact, 70% of the beds for men in Massachusetts are at a prison facility, where patients wear prison uniforms and answer to correctional officers. In recent months, these facilities have been rocked by a series of high-profile scandals, including escapes, suicides, and alleged sexual assault.

Do these laws help or hurt?

Existing data on both the short- and long-term outcomes following involuntary commitment for substance use is "surprisingly limited, outdated, and conflicting." Recent research suggests that coerced and involuntary treatment is actually less effective in terms of long-term substance use outcomes, and more dangerous in terms of overdose risk. The prospects for positive outcomes from the CARE Act are especially bleak, given the standard of care currently available to Massachusetts residents committed under Section 35. The facilities housing Section 35 patients commonly offer counseling sessions and classes to "learn more about addiction;" shockingly few offer appropriate medication. In fact, the treatment provided is often not rooted in science at all. The state's own mandated evaluation of overdose data has found that people who were involuntarily committed were more than twice as likely to experience a fatal overdose as those who completed voluntary treatment.

Though further research is needed to confirm these findings, there are several possible reasons for this. One is that recovery is much more likely when it is driven by internal motivation, not by coercion or force (i.e., the person must "want to change"). Second, the state may actually route individuals to less evidence-driven programs on average (e.g., "detox") than the kind of treatment accessed voluntarily (i.e., outpatient methadone or buprenorphine treatment). Finally, those receiving care in outpatient settings may be more likely to receive services that help address underlying physical or mental health needs, which are often at the root of problematic substance use.

Involuntary commitment for people with substance use disorder deprives them of liberty, fails to offer evidence-based treatment, and may leave patients worse off by making them vulnerable to overdose risk. But for the families or medical providers of individuals with substance use disorder, court-ordered involuntary commitment for their loved ones or patients may seem like an attractive option, or indeed the only viable one, to get them into treatment. Understanding the procedures, ramifications, and consequences of involuntary commitment is vital before initiating a process that deprives a person of liberty just as much as prison would.

What is the alternative?

There is far too little on offer in Massachusetts — or elsewhere — that would trigger the timely assistance and intensive case management necessary to support people in crisis. In the absence of such supports, involuntary commitment promises to help families that are desperate to find treatment for their loved ones. Unfortunately, the promise offered by involuntary treatment is a false one. Instead, we need to develop new approaches to support families and patients in non-coercive, evidence-driven ways.

Related Information: Understanding Opioids: From addiction to recovery

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People Struggling With Addiction Need Help. Does Forcing Them Into Treatment Work?

It depends on the type of coercion you use.

By CARL ERIK FISHER
JAN 18, 20189:07 AM

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As an addiction psychiatrist, I'm often faced with this situation: A desperate person reaches out to ask how they can force their family member into drug or alcohol treatment. A sister has had multiple car crashes, or a husband can't quit drinking, or a son or daughter keeps overdosing. In New York, where I practice, there's a simple answer: If they don't want treatment, there's no legal way to compel them. That's how most clinicians practice in the U.S. But with growing

nationwide concern about the opioid crisis, some people are rethinking the use of coercion in addiction treatment.

There are only a handful of U.S. states that regularly mandate people with addiction into treatment against their will (that is, outside of the more common drug court approaches, in which, *after* getting charged with a crime, people might be offered treatment instead of punishment). But recently, lawmakers in other states from New Hampshire to Alabama have crafted new laws expanding compulsory treatment. For example, bills proposed in Pennsylvania would allow families to commit their relatives into locked-down inpatient facilities, or require people to attend treatment after drug overdoses, or else face jail time. As other commentatorshave noted, on a policy level, these new laws are counterproductive because they would shunt crucial resources away from more effective measures, such as expanding our network of traditional treatments for those seeking help. But the trend toward involuntary treatment points toward an important empirical question: Does coerced treatment actually work?

Even outside of formal legal measures, coercion is already woven into the fabric of U.S. addiction treatment: Up to 75 percent of people in treatment programs say they are there because of some formal or informal pressure. The very nature of addiction makes some forms of coercion inevitable; as long as some people experience denial and resistance about their substance use problems, they will be pressured into treatment rather than seek it out on their own. So what is called "coercion" is not homogenous—it runs the gamut from friendly personal leverage to a true legal mandate or court order. It's this spectrum that demands a close consideration so that we can reach a more nuanced understanding—and given that coercion is so ingrained in our society, to understand how we can work with it most helpfully and minimize its possible dangers.

The very nature of addiction makes some forms of coercion inevitable; as long as some people experience denial and resistance about their substance use problems, they will be pressured into treatment.

Coerced treatment is a fiercely debated topic in addiction. Major organizations are at odds over the idea: Several U.N. programs have spoken out against compulsory treatment, calling it harmful, but the National Institute of Drug Abuse asserts that treatment need not be voluntary to be effective.

One major reason for this disagreement is a confusion in terms. Even many researchers and clinicians make the error of assuming that *coercion* refers only to the most absolute forms of control. But there is a big difference between formal and informal coercion. In everyday language, the word coercion implies force or threats, but in a more precise sense it simply means a hard choice. Formal, legal coercion gets more attention, but informal coercion is far more common—such as when friends, family, or employers make someone choose between seeking treatment and losing a relationship or a job.

People have studied coerced addiction treatment, but it's a messy process to fit into the usual experimental trial framework, and the studies tend to focus on formal coercion. A 2015 structured review of the most rigorous studies found that coerced treatment was generally no better than treatment as usual. Critics of coercion have interpreted these results to say that we don't know whether coerced treatment has any effect—or whether it works at all. But this is an

odd interpretation. The key question should not be whether compulsory treatment is any better than, but if it is simply at least as effective as, usual voluntary treatment. We shouldn't expect compulsory treatment to outperform traditional treatment.

For example, one of the largest and most rigorous studies of coerced addiction treatment was a Veterans Affairs investigation of over 2,000 patients published in 2005. Patients who had been mandated to treatment generally improved at the same rate as people entering treatment voluntarily, scoring as well or even sometimes better on measures like being abstinent, having no consequences from substance use, being employed, and avoiding re-arrest. This isn't a negative finding, it's an equivalence study: It shows that on average, people who were forced into treatment did at least as well as people voluntarily entering.

True, there have been conflicting findings from other studies, so we should be careful about drawing sweeping conclusions. Other research has found different types of compulsory treatment to be associated with worsened treatment outcomes and increased criminal activity, and some evidence suggests that the purported benefits of mandated treatment don't last after the mandate is finished. The ultimate conclusion of that structured review was that we just don't have enough evidence today. But even beyond that conclusion, the biggest, meta-level limitation to these investigations, and the reasons their findings don't generalize to more common forms of coercion, is that they only study the most basic indicators of formal coercion.

ADVERTISING
In most studies, researchers only track whether someone has been formally, legally mandated, while ignoring informal coercion from friends and family. They also treat the mere presence of a legal referral as a monolithic indicator, as if all those mandated patients are having the same experience. It's true that this is how we study medications: Split a population into two neat groups and try to isolate one variable. But mandated treatment is far more complicated than the binary presence or absence of a medication. For example, research shows that the presence of a legal mandate simply isn't a reliable proxy for an individual's perception of coercion. People's internal experience is missing in these studies, and as it turns out, that internal experience matters a great deal.

Studies that focus on the perceptions of people with addiction are not included in the more concrete, structured reviews of coercion's effectiveness, but investigators have found that those internal experiences have a significant effect on treatment outcomes. They are perhaps more influential than the presence of coercion itself.

For example, one set of studies based on a psychological model called Self-Determination Theory has found that for people who were mandated into treatment, their perceptions about the treatment may matter much more than the objective presence of external coercion. When asked directly, some people who were mandated said they still felt like they were in control all along, and some people entering "voluntarily" said they felt like entering treatment was not really their choice. People with more of a sense of agency have better outcomes, such as retention in treatment—it could be that this effect is greater than the presence of the legal mandate itself.

The key is to look at people with addiction as active decision-makers and foster their own sense of engagement and motivation.

It makes sense: Of those desperate people who contact me, some decide to put serious pressure on their loved ones. They threaten their struggling family members with severing the relationship and standing back to watch them hit "rock bottom." There's no reason those struggling people shouldn't feel just as trapped as those who've been court-ordered into treatment. "Tough love" that forces people to get help or face strict consequences is not a helpful strategy, but years of studies have shown that regular, kind, but boundary-based support is more effective. These kinds of actions—like setting clear and nonjudgmental expectations about money or other support, positively reinforcing healthy behavior, and offering help—can lead people with substance use problems toward positive change and real, self-motivated engagement in treatment. These self-determination studies help to explain why that might be so, and the findings suggest tweaks to the fundamental question: not "does coercion work?" but what kind of coercion works, and how should one work within coercive structures?

Our society is enamored with "law and order" approaches to social problems. We generally overvalue formal legal coercion through mechanisms like drug courts and compulsory treatment, and undervalue softer, less extreme forms of coercion from employers, friends, and family. One unfortunate consequence of this attitude is, even though informal coercion is much more common, its research base is weak. We need more studies outside of the all-or-nothing, confrontational approach to formal legal coercion. And pragmatically, we are probably too quick to resort to extreme measures and too tentative about navigating the middle ground, such as applying some constructive and kind pressure without being absolute or punitive. People can use informal coercion in a way that still preserves a sense of choice and agency—in which coercion isn't a threat but simply a hard choice. Most people believe that kind of informal pressure to be wishy-washy, but there is good evidence to suggest it is more effective than stricter policies. The key is to look at people with addiction as active decision-makers and foster their own sense of engagement and motivation. We should be taking that approach with everyone, including (and especially) those who have been formally mandated into treatment. Aside from being more humane, it simply works better.

One more thing

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Join

May 11, 2019, via e-mail

City and County of San Francisco Rules Committee
City Hall, Legislative Chamber, Room 250
San Francisco, CA

Re: Implementation of SB 1045 and SB 40, File # 181042
Board of Supervisors Rules Committee, May 13, 2019

To: Supervisors Ronen, Walton, Mar: Constituent Statement for the record of hearing.
Cc: The Honorable Mayor London Breed, and Supervisors Brown, Fewer, Haney, Mandelman, Peskin, Safai, Stefani, Yee

Dear Supervisors Ronen, Walton, and Mar:

My name is Colette I. Hughes. I am a San Francisco based patients' rights attorney, former nurse and a long time resident of the Mission District. This statement is in opposition to the implementation of SB 1045 by the City and County of San Francisco and in opposition to SB 40.

SB 1045 and SB 40 do not propose solutions that meet the goal of addressing the homelessness epidemic in San Francisco. Nothing in the bills expands housing or access to behavioral health or other basic care services needed by homeless people diagnosed as having a serious mental illness, a substance use disorder, or who are dually diagnosed. The two bills punish the homeless for their status and discriminate against people with disabilities.

SB 1045 makes the trigger for the conservatorship 8 or more 5150 detentions in the preceding 12-month period. SB 40 would change this provision to mean 8 or more detentions in any 3-month period. The bills require no mechanism for monitoring or responding to the use or misuse of the 5150 process under the new scheme. A conservatorship petition would only need to be timely filed with the court once the 5150 quota is met. Eight strikes and you're out! And you are out of San Francisco too, as the City does not have the services, the housing or the placements to meet to meet your individual needs. This is why about 65% of San Francisco conservatees are in placements outside their community of San Francisco.

Imposition of a conservatorship often involves involuntary placement in a locked facility far away from family and friends, and the imposition of additional legal disabilities, including the right to make one's own treatment decisions. Implementation of SB 1045 could place certain individuals at undue risk of emotional and physical harm from transfer trauma, also known as relocation shock. The phenomena, which results in increased morbidity and mortality, is a result of the involuntary, precipitous or haphazard relocation of at-risk individuals including the elderly and homeless people with health conditions and disabilities. A related

concern is the harm that could befall persons with special needs, including transgender individuals who suddenly find themselves isolated in a facility far away from their support network and their community. The increased risk of suicide under such circumstances should not be underestimated.

Involvement of law enforcement in the implementation of this new conservatorship program is ill advised. Approximately 60 percent of individuals subjected to lethal force by law enforcement in San Francisco every year are identified as having a psychiatric disability. Calls for well-being checks have ended in tragedy throughout our country. Implementation of SB 1045 would open the door to more instances of force and physical harm of the homeless and the disabled during interactions with law enforcement personnel. The bills would allow conservatorship of the person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance abuse disorder, as demonstrated by the imposition of eight 5150s.

Public policy should be limiting the role of law enforcement in the mental health commitment process. SB 1045 and SB 40 would give San Francisco law enforcement an unprecedented role in causing individuals to be subject to a loss of basic human rights under a new and sweeping conservatorship program once the detention quota is met. These bills pose a considerable threat of misuse of the 5150 process by law enforcement. According to a May 6th, 2016 report by The California Hospital Association, about 300,000 5150s for detention and transport on an involuntary hold pursuant to 5150 are written annually. More than 75% of the detainees were discharged within 23 hours and less than 25% were determined to require treatment on an inpatient unit. This means that the majority of people 5150'd by the police are found not to meet the standard for involuntary detention by qualified mental health professionals less than 24 hours of being transported to the facility by law enforcement.

If SB 1045 is implemented, police officers will likely experience greater pressure to 5150 homeless people. Implementation could also undermine community outreach policing efforts to marginalized homeless people. The measures also allow the county sheriff, who is not a qualified mental health professional, to recommend this new form of conservatorship for homeless and disabled jail detainees. San Francisco should refrain from moving forward with this dangerous experiment.

Conservatorships are not inherently objectionable. However, implementation of SB 1045 and SB 40 represent the needless expansion of involuntary care mechanisms and invite mistreatment of those the measures purport to protect. In addition to conservatorships based upon grave disability under the Lanterman-Petris-Short Act (LPS), San Francisco already has Assisted Outpatient Treatment which allows for the involuntary treatment of individuals "unable to carry out transactions necessary for survival or to provide for basic needs." Homeless individuals who refuse available care for their life-threatening medical conditions meet this standard and are regularly conserved by the mental health courts when determined necessary.

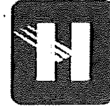
The new SB 1045 conservatorship scheme violates a fundamental premise of the LPS Act that all people with psychiatric disabilities should be treated in a manner which enhances their personal autonomy and self direction. The societally imposed condition of homelessness does not change this universal principle. SB 1045 and SB 40 erroneously assume that homeless people are to blame because they are resistant to care when in fact it is the lack of housing, basic medical and other services that is responsible for the absence of care. This absence of basic services was underscored at the Board of Supervisors Budget Committee Hearing on Mental Health and Substance Abuse on May 1st, 2019, when department representatives informed the Committee that there is a 20% deficit in skilled personnel including psychiatrists and case managers and that 44% of patients who successfully complete treatment programs are discharged to homeless shelters or to the streets. Every day there are over 1,000 people on the city's single adult Shelter Reservation Waitlist. And according to 2018 behavioral health audit, 38% of people discharged from psychiatric emergency services were not offered any continuing services. This is not care; it's systemic neglect.

The bills actually disfavor the provision of meaningful voluntary services and provide no assistance to address the re-traumatization of the 5150 and involuntary psychiatric hospitalization experience. Healthcare workers worry that the implementation of SB 1045 would require them to participate in a process that violates the ethical mandate to "do no harm." And although SB 1045 requires that there be no reduction of voluntary services, the legislation does not and cannot fulfill that promise. Given the dearth of services to meet the need, and the failure of the legislation to identify additional funding and resources, it would be impossible to refrain from cutting access to voluntary services in order to impose the conservatorships envisioned under the new scheme.

The implementation of SB 1045 would be fiscally irresponsible. Institutional beds cost the City about $164,000 a year per individual. For a fraction of this amount San Francisco could provide quality voluntary housing with wrap around services to the identified individuals in need. Long-term stable housing and supportive recovery services substantially improve the lives of homeless people with disabilities. We can and must make this happen in San Francisco. Implementation of SB 1045 would serve expediency but not the homeless; it would interfere with our ability to create a system that works, and would divert attention and sparse resources from those truly in need.

Respectfully submitted,

Colette I. Hughes
77 Fair Oaks Street
San Francisco, CA 94110
415-503-9664
coletteihughes@gmail.com



Hospital Council
of Northern & Central California

Excellence Through Leadership & Collaboration

May 9, 2010

The Honorable Hillary Ronen
Board of Supervisors
Rules Committee, Chair
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

Subject: Support – Housing Conservatorships (File Number 181042)

Dear Supervisor Ronen:

Thank you and the honorable members of the Rules Committee for addressing the important health issues in San Francisco.

The Hospital Council supported SB 1045, the enabling state legislation to expand, as a pilot program, San Francisco's existing conservatorship program to serve individuals suffering from serious mental illness and substance use disorder, whose needs are unmet by voluntary services. And, we support this ordinance and appreciate the leadership of the ordinance sponsors.

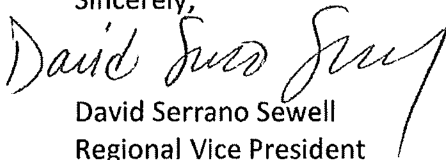
Our community believes that patients should get the right care at the right place so as to achieve optimal health outcomes. As part of the City's network of patient care, hospitals are confronted with the daily challenges of treating patients that are unable to make the best health decisions for themselves. Sometimes this care happens in the highly impacted emergency departments, which is not the ideal setting.

While not a complete solution to the totality of the City's behavioral health challenges, this ordinance is an essential tool to help those get the care needed and in the appropriate setting. It is a positive step forward.

Further, the state law and ordinance are drafted to include due process protections to ensure the civil liberties of conservatees, which is important.

We urge you to support this ordinance. Thank you for your consideration.

Sincerely,



David Serrano Sewell
Regional Vice President

Regional Office 235 Montgomery Street, Suite 910 San Francisco, CA 94104-3004 415.616.9990 Fax: 415.616-9992

May 13, 2019

San Francisco Board of Supervisors
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA, 94102

Dear Honorable Members of the Board of Supervisors,

As mental health professionals who work with individuals with serious mental illness, substance use disorders, physical disabilities, chronic diseases, histories of homelessness, and more, we are writing to urge your support for local implementation of SB 1045 (File Number 181042), sponsored by Mayor Breed and Supervisor Rafael Mandelman, and co-sponsored by Supervisors Brown and Stefani. SB 1045 is not a solution to the homelessness crisis, nor will it address the needs of the larger population suffering from untreated mental illness on our streets. But it is an urgently-needed tool that will help providers like us deliver care to a small population of the sickest people suffering on our streets.

Opponents argue that San Francisco should not implement SB 1045 because we do not have treatment available for all who voluntarily seek it, that we should focus on expanding voluntary services first. As mental health professionals we agree that system-wide reform is needed, and that we as a City must provide treatment on demand and housing or shelter to all who need it. However, this is not an excuse to deny the treatment, services, and supportive housing SB 1045 will provide to a small number of individuals whose disabling conditions prevent them from seeking care on their own. We should not sacrifice the lives of people in crisis in the name of a perfect system.

Every day we work with our clients to help them make healthy decisions for themselves, engaging them in treatment and care plans that include a variety of voluntary services. In many cases, our clients choose treatment, accept services, and go on to make positive changes in their lives. We applaud those who do, and continue to support them on their journey to health and recovery. But we want the same chance at success for all of our clients, including those for whom severe mental illness and addiction have eroded the capacity to seek and accept care. SB 1045 will allow us to finally wrap our arms around those individuals who may not recognize their own illness, but who urgently need care. We believe they deserve this opportunity to heal.

As mental health professionals, we see the urgent need in this City to expand the definition under which individuals in crisis may be provided appropriate behavioral health treatment that works, while giving us the tools we need to intervene and drive positive change for the people we serve. We urge you to implement this new pilot program to allow us to provide the assertive community treatment required to assist this particular population in exiting the continuous cycle of crisis, illness and the deleterious impacts to their health and our city as a whole. Please consider the voice of mental health professionals, and vote yes on SB 1045.

Sincerely,

Rachel Rodriguez, LCSW
Mel Blaustein, MD Psychiatrist
Sarbani Maitra, MD Psychiatrist
Yasi Shirazi, LMFT
Erik P. A. Deiters, MA
Paula Pulizzi, LMFT
Canidce Rugg, Psych NP
Makan Talayeh, MD Psychiatrist
Monique Cortes, LCSW
Meredith DeHaas, MSW, ASW
Jordan Pont, LMFT
Brenna Alexander, MSW Student
Monique Hamilton, LCSW
Maggie Chartier, PsyD, MPH

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Charles Berman, LCSW
David Ogami, MD Psychiatrist
Mehera Reiter, LCSW
Trung Du, MSW, ASW
Olivia Salvador, LCSW
Nina Strongylou, LMFT
Bronwen Lemmon, LMFT
Julie Maxson, LCSW
Robert Robles, LCSW
Annie Keilman, LCSW
Elizabeth Rahner, MPH MSBH
Abigail Kahn, LCSW
Jesse Wennik, NP, CNS
Marjorie Cabrera, MSW, ASW

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Young, Victor (BOS)

From:	PENNI WISNER <penniw@pacbell.net>
Sent:	Monday, May 13, 2019 4:04 PM
To:	Young, Victor (BOS)
Subject:	SB1045 proposed legislation for SF

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

The public comment line was so long today, I could not stay.

But I am a strong supporter of the Housing Conservatorship legislation discussed today 13 May at the Rules Committee hearing.

It is a small, pilot project that targets a difficult-to-reach, highly disabled group who have refused voluntary services and are frequent users of emergency services.

Transparency is built into the project with the working group. The project is a new tool when all the old ones have failed.

It is not kind or compassionate to let such people deteriorate on the streets in the name of "civil rights". We know that they have been diagnosed with severe mental illness compounded by an additiction and thus are often paranoid and distrustful. The conservatorships will not last that long, just hopefully long enough to get some of them stabilized and even on the road to better health.

As we muddle about doing nothing in the pursuit of the perfect, the crisis grows. More people die, more citizens get angry that nothing changes. Nobody wins.

We are asking the people who reach out to these people, who take them to the hospital day after day, who know they could be helped, to pay an extradordinarily high price. That, too, should be factored into why we need this potential solution for this small group.

Let's pass this legislation and give some of this group a chance to succeed.

With respect,

Penni Wisner
3845 17th Street
SF, CA 94114
penniw@pacbell.net

Hickey, Jacqueline (BOS)

From: Colette Hughes <coletteihughes@gmail.com>
Sent: Saturday, May 11, 2019 12:00 PM
To: Hilary.Ronen@sfgov.org; Walton, Shamann (BOS); Mar, Gordon (BOS)
Cc: Breed, Mayor London (MYR); Brown, Vallie (BOS); Fewer, Sandra (BOS); Haney, Matt (BOS); Mandelman, Rafael (BOS); Peskin, Aaron (BOS); Safai, Ahsha (BOS); Stefani, Catherine (BOS); Gordon.Yee@sfgov.org
Subject: Constituent Statement for the May 13, 2019 meeting
Attachments: PDFTestimonySB1045 & SB 40.pdf

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May 11, 2019
Dear Supervisors Ronen, Walton, and Mar,
Here is my statement for the record on the hearing this coming Monday about the potential implementation of the Housing Conservatorship Program per Ordinance in File No. 181042.
I thank you for reviewing this.
Sincerely,
Colette I. Hughes

Young, Victor (BOS)

From: Calvillo, Angela (BOS)
Sent: Friday, May 10, 2019 5:39 PM
To: Young, Victor (BOS)
Cc: Somera, Alisa (BOS)
Subject: FW: URGENT - OPPOSE IMPLEMENTATION OF SB 1045 (CONSERVATORSHIP)

For the file.
Thank you.
Angela

From: Jesse Stout [mailto:jessestout@gmail.com]
Sent: Thursday, May 09, 2019 8:02 PM
To: Ronen, Hillary <hillary.ronen@sfgov.org>; Walton, Shamann (BOS) <shamann.walton@sfgov.org>; Mar, Gordon (BOS) <gordon.mar@sfgov.org>
Cc: Calvillo, Angela (BOS) <angela.calvillo@sfgov.org>; Board of Supervisors, (BOS) <board.of.supervisors@sfgov.org>; Peskin, Aaron (BOS) <aaron.peskin@sfgov.org>; Stefani, Catherine (BOS) <catherine.stefani@sfgov.org>; Yee, Norman (BOS) <norman.yee@sfgov.org>; Fewer, Sandra (BOS) <sandra.fewer@sfgov.org>; Mandelman, Rafael (BOS) <rafael.mandelman@sfgov.org>; Safai, Ahsha (BOS) <ahsha.safai@sfgov.org>; Brown, Vallie (BOS) <vallie.brown@sfgov.org>; Haney, Matt (BOS) <matt.haney@sfgov.org>; Goossen, Carolyn (BOS) <carolyn.goossen@sfgov.org>; Morales, Carolina (BOS) <carolina.morales@sfgov.org>; Gee, Natalie (BOS) <natalie.gee@sfgov.org>; Quan, Daisy (BOS) <daisy.quan@sfgov.org>; Gallardo, Tracy (BOS) <tracy.gallardo@sfgov.org>; Angulo, Sunny (BOS) <sunny.angulo@sfgov.org>; Hepner, Lee (BOS) <lee.hepner@sfgov.org>; Cathy Mulkey Meyer <Cathy.mulkey.meyer@sfgov.org>; Temprano, Tom (BOS) <tom.temprano@sfgov.org>; Cancino, Juan Carlos (BOS) <juancarlos.cancino@sfgov.org>; Derek ramski <derek.ramski@sfgov.org>; Simley, Shakirah (BOS) <shakirah.simley@sfgov.org>; Honey Mahagony <honey.mahogony@sfgov.org>; Abigail Rivamonte Mesa <abigail.rivamonte.mesa@sfgov.org>; Fregosi, Ian (BOS) <ian.fregosi@sfgov.org>; Mundy, Erin (BOS) <erin.mundy@sfgov.org>; Smeallie, Kyle (BOS) <kyle.smeallie@sfgov.org>; Edward Wright <edward.wright@sfgov.org>; Ho, Timothy (ADM) <tim.ho@sfgov.org>; Donnelly-Landolt, Wyatt (BOS) <wyatt.donnelly-landolt@sfgov.org>; Burch, Percy (BOS) <percy.burch@sfgov.org>; Lee, Ivy (BOS) <ivy.lee@sfgov.org>; DPH-jessica <jessica@sdaction.org>; indivisible.spencer@gmail.com; Lily Haskell <lily@criticalresistance.org>; Roma Guy <romapguy@gmail.com>
Subject: URGENT - OPPOSE IMPLEMENTATION OF SB 1045 (CONSERVATORSHIP)

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Hello; I'm Jesse Stout; I live in District 6; I'm a member of the No New SF Jails Coalition. I am writing to ask that the Board of Supervisors vote NO on the idea of creating a new conservatorship system controlled by the number of times police pick someone up. This is an expensive new program that does not actually provide the mental health services, substance use treatment, and housing that people really need. Can I count on you to vote NO on this ordinance in the Rules committee on May 13?

SB 1045 puts the determination for a new form of conservatorship into the hands of police, by shifting the long-supported standard for conservatorship from "harm to self or others" to "number of police detentions under 5150." City and state officials admit problems with SB 1045 and are in the process of amendments. The City does not meet the legal requirements under SB 1045.

Regards,
Jesse Stout

No New SF Jails Coalition

--
CurbPrisonSpending.org

Young, Victor (BOS)

From: Jordan Davis <jodav1026@gmail.com>
Sent: Saturday, May 11, 2019 3:26 PM
To: Board of Supervisors, (BOS); Young, Victor (BOS)
Subject: SB1045 Bad For The Trans Community (Oppose File: 181042)

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Supervisors Ronen, Walton, and Mar;

I have discussed with you extensively about local implementation of SB1045 and why it is an extremely bad idea. We've discussed the fact that it creates a new form of conservatorship that shifts the criteria from "harm to self or others" to "homeless and receives 8 detentions under 5150" (interestingly enough, that means 8 statements of competency from psych emergency services means that you are incompetent). We have discussed the criminalization, lack of implementation plan, lack of services, and SB40, but I want to bring up what will happen to the trans community.

We have brought up that the low numbers of people currently eligible for 1045 conservatorship are low, and how SB1045 could lead to more police harassment. According to the National Coalition on Anti-Violence Programs, transgender people are 3.7 more times to experience police violence than cisgender survivors and victims of anti-LGBT violence. Trans women are 4 times more likely, and this number is likely elevated for transgender women of color and disabled transwomen

Also, according to the Our Trans Home SF website, up to 49% of TGNC San Franciscans have experienced homelessness at some points in their lives, and 49% of homeless youth in SF identity as LGBTQ. This number is likely higher for transgender women of color and/or disabled trans women.

Mental health is also a major issue in the transgender community, as an alarming 41% of transgender people surveyed have considered suicide, over 25 times the national average. This number is likely much higher for transgender women of color and disabled transwomen.

However, SB1045 is not the answer, and according to Susan Mizner, a lawyer and founder of ACLU's Disability Rights Program: "Someone who is put under conservatorship loses their right to choose where they live, who they associate with, whether they get to keep their pet, what they do with their day, whether they see this therapist or that therapist. It is, from our perspective as the ACLU, the greatest deprivation of civil liberties aside from the death penalty."

So, what will happen to trans people when they are conserved. There are concerns about individuals being sent out of county, and while transgender people face challenges in the Bay Area, we may find that trans people who are conserved will be sent to board and cares in the Central Valley or other parts of the state which are not so friendly to the transgender community, and may have no ability to contact their peers and be forced into transphobic settings, and might be forced to see transphobic therapists, and be forced to live as a gender they are not. They may be forced to cut their hair, wear gender incongruent clothing, be denied gender affirming medical care, not be able to have their name changed, and face violence and abuse.

All because a transgender person was homeless and was dealing with mental health issues that may or may not be rooted in discriminatory attitudes, and the police 5150ed them a certain number of times (even if psych emergency services found them competent).

For many reasons, I cannot support this legislation, and there are plenty of transgender advocates who do not support this either, including TGIJP, which has signed onto a statement of the Voluntary Services First Coalition. I hope you will consider other alternatives, as this is a false solution that could do grave harm to San Francisco's transgender community.

Regards,
-Jordan Davis
Member of: Voluntary Services First Coalition, Senior & Disability Action, Our City Our Home Coalition, and the Democratic Socialists of America, San Francisco chapter.

Young, Victor (BOS)

From:	Ann Cromey <anncromey2@gmail.com>
Sent:	Saturday, May 11, 2019 5:46 PM
To:	Young, Victor (BOS)
Subject:	File #181042

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Senate Bill 1045, to create Housing Conservatorships for people suffering from mental health and substance use, is a very important and humane piece of legislation, which will help to make San Francisco a much more salubrious place to live. Please adopt this bill.

Elizabeth Ann and Robert Cromey
3839-20th Street
San Francisco, 94114

May 10, 2019

Rules Committee Chair Ronen
Supervisor Mar
Supervisor Walton
1 Dr Carlton B Goodlett Place
San Francisco, CA 94102

RE: Opposition to Housing Conservatorship Program SB 1045/File #190372

Dear Chair Ronen, Supervisor Mar, and Supervisor Walton,

On behalf of HealthRIGHT 360, I urge you to oppose the implementation of SB 1045, Housing Conservatorship Program. HealthRIGHT 360 has grave concerns about San Francisco's planned implementation of this program that introduces substance misuse as a criterion to limit the civil rights of individuals and allows for forced treatment for substance use disorder – something that is unprecedented in our community.

Even evidence-based diversion programs like Drug Courts allow individuals to *choose* substance use disorder treatment as an alternative to incarceration. **With the implementation of the planned conservatorship program, the City will be crossing a bright line by forcing its residents into treatment for addiction at the expense of their civil liberties.** This runs contrary to efforts to reduce high incarceration rates associated with addiction.

Conservatorship under SB 1045 over-relies on engagement with the law enforcement, through a shift from the long-supported standard for conservatorship from *harm to self or others* to *number of detentions under 5150*. With existing gaps in the City's behavioral health safety-net, the process described in the City's implementation plan leapfrogs over needed fixes to the system that could prevent the City's residents from ever meeting the new conservatorship criteria in the first place, most notably improved care coordination and the need for sustainable transitions out of emergency and other services.

The appointment of conservators does not address the challenges associated with the City's insufficient capacity for behavioral health and housing resources, much of which was discussed in the May first hearing of the Board of Supervisors' Budget and Finance Committee. For example, last year, 38% of the time people were discharged from Psychiatric Emergency Services without appropriate step-down services[1]. We should be focusing our resources on filling known gaps in our safety-net before we force people into treatment by expanding the conservatorship program.

[1] Performance Audit of the Department of Public Health Behavioral Health Services. Prepared for the Board of Supervisors of the City and County of San Francisco by the San Francisco Budget and Legislative Analyst April 19, 2018 Page vii

Thank you for your consideration of this issue. Please let me know if you would like more detail about the concerns expressed herein, I would welcome the opportunity.

Sincerely,

Lauren Kahn

Lauren Kahn
Managing Director of Policy and Communications
Gender Pronouns: She/Her
Mobile: 415-525-2203
LKahn@healthright360.org

Cc: Board of Supervisors President Yee
Supervisor Brown
Supervisor Fewer
Supervisor Haney
Supervisor Mandelman
Supervisor Peskin
Supervisor Safai
Supervisor Stefani

Young, Victor (BOS)

From: Carolyn <carolynj0@yahoo.com>
Sent: Thursday, May 09, 2019 6:35 PM
To: Young, Victor (BOS)
Subject: re: Conservatorship File 181042

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

Supervisors:

I urge you to implement the proposed Conservatorship Plan for SB 1045 in the City and County of San Francisco.

I'd counter the opponents' view of individual rights being at risk with this argument:
* there is precedent for government to step in when the good of an entire population's health is at stake. Requiring individuals to be vaccinated to maintain the public well-being is a recent example. Another example - health officials enforce a quarantine when there is risk of an outbreak like Ebola. If left to an individual's decision, would the quarantine be the choice?

Certainly there are times when the health and well-being of the larger group outweighs an individual's ill-informed choice to be un-vaccinated or remain free. While the degree of freedoms might be different, the argument for a greater good still prevails.

Additionally, SB-1045 is set up as a pilot program. The program has built in safeguards and will be heavily scrutinized. Success should be weighted towards a healthier individual and healthier environment for the city. A pilot ensures that If there are flaws, the program can be adjusted or dismantled.

The asylum institutions of old are much assailed by the opponents to the proposed pilot program. Instead, what we've allowed to happen, is for our streets to become an open asylum — with no 24-hour staff. This isn't fair to any of the parties - those not requesting, but needing assistance; nor those wishing for healthy streets.

That the city has both seriously mentally ill and drug addicted people on the streets without appropriate and consistent care is not in question, only how many people fit a specific and narrow criterion. Any number, places the entire city at risk and creates bedlam.

Please take this opportunity to make some small difference, give some of our population a chance for recovery. Vote for the pilot program.

Sincerely,
Carolyn Thomas

From: B Gladstone <bmgsfc@gmail.com>
Sent: Sunday, May 12, 2019 8:50 PM
To: Young, Victor (BOS)
Subject: sb 1045 support - reference File 181042.

This message is from outside the City email system. Do not open links or attachments from untrusted sources.

I see all the effects of entrenched homelessness every day. I tell my 16 y/o daughter how lucky she is to live here, but she dreams of living in the country.

To govern is to cooperate with others to craft solutions to problems, and often this is an iterative or trial and error process. I am a paying member of the ACLU, but they and other organizations are getting it wrong by focusing on the worst case scenario of loss of liberty. As an example of the balance of individual rights and the good for the community, consider the recent measles outbreaks and the refusal by some to get vaccinated.

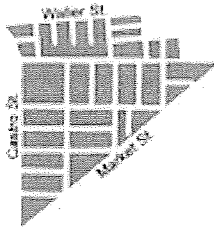
Certainly there are times when the health and well-being of the larger group outweighs an individual's ill-informed choice to be un-vaccinated or remain free. While the degree of freedoms might be different, the argument for a greater good still prevails.

SB-1045 is set up as a pilot program. The program has built in safeguards and will be heavily scrutinized. Success should be weighted towards a healthier individual and healthier environment for the city. A pilot ensures that If there are flaws, the program can be adjusted or dismantled.

To fail to implement SB 1045 sends the message of endless inaction, hand wringing and posturing on the part of this city's government. Please step up to the challenge. Implement, learn, improve, and repeat. No idea is perfect. This is 1 important idea for a colossal problem. It is not a panacea, but let's put this in motion and work to make the city healthier for all.

Thank-you,

Bruce M Gladstone



Duboce Triangle Neighborhood Association
PMB # 301, 2261 Market Street, San Francisco, CA 94114
(415) 295-1530 / www.dtna.org

May 10, 2019

To Whom It May Concern:

The Board of Directors of the Duboce Triangle Neighborhood Association (DTNA) has unanimously voted to support the pending legislation to adopt SB 1045, Housing Conservatorships.

Although the legislation being considered may only help a small number of people, they are individuals who truly need help that only this legislation can provide.

Too often in San Francisco, we use faux compassion to mask our unwillingness to do what is difficult or feels uncomfortable. Please don't let this be one of those times. It is not kind or compassionate to let people destroy themselves, day by day, on the streets of our city.

Please vote to support this carefully-crafted and appropriately-limited conservatorship legislation.

Sincerely,

Duboce Triangle Neighborhood Association Board of Directors

David Troup,
for the Board of Directors

April 29, 2019
San Francisco Board of Supervisors
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102

the individual right to possess and carry weapons
the individual right to hate speech
the individual right to refuse medical care for your children
the individual right to marry a teenager
the individual right to refuse vaccinations
the individual right to openly use drugs
the individual right to refuse mental health care

The United States is addicted to it's individual rights.
And quite literally, it is killing us.

Is the right to freedom worth the cost of people dying on the streets and in schools? Is it worth the continuous vitriolic national dialogue? The bitter division? Both political extremes deploy these tactics to hold firm on their beliefs. They serve only those individuals, mostly in the extreme minority of populations. And for the rest of us, we are left with crime, hatred, death, and social instability.

Many of the members on the Board of Supervisors believe that yes, individual rights are worth the social cost.

May I take this opportunity to remind you that hundreds of thousands of San Francisco residents are strained, frustrated and desperate to stop absorbing it.

Please support SB1045

INDIVISIBLE SF

Date: May 7, 2019

To: San Francisco Board of Supervisors Rules Committee

cc: Jessica Lehman, Executive Director, Senior and Disability Action

re: SB 1045 and SB 40 - **OPPOSE**

Indivisible SF, a member of Voluntary Services First, is opposed to the implementation of SB 1045 and SB 40 that expand the use of conservatorship to people with mental illness and substance use disorder. We respectfully ask that you vote **NO** on File # 181042 when it is heard by the Rules Committee on May 13, 2019.

San Francisco suffers from a substantial lack of much-needed voluntary services. Given this lack, the City's resources should be directed towards providing adequate supportive housing, mental health care and substance abuse treatment for the thousands of San Francisco residents who are on waiting lists for these voluntary services. Until the City has adequate funds and resources for voluntary services, we oppose expansion of involuntary conservatorship.

SB 1045 and SB 40 shifts the long supported standard for conservatorship from "Harm to self and others, or gravely disabled" to "Number of police detentions under 5150". Decisions about mental health care and substance use disorder treatment should be made by patients, their families and their physicians, not by the police and the courts. Conservatorship is an extreme deprivation of civil rights. That is why the long accepted standard is "harm to self or others, or gravely disabled", only to be used in extreme cases.

While there may be a very small number of patients who meet the standards set out in SB 1045 and SB 40, there are many more homeless people who are detained under a 5150 hold who do not meet the criteria. They are arrested, transported to emergency psychiatric care facilities and then released. However the trauma inflicted by this process can be permanent and devastating.

Furthermore, there is mounting evidence that compulsory treatment, especially without adequate follow-on care, is ineffective and can actually exacerbate the patient's condition. The UN has issued joint statement calling for the closing of compulsory treatment centers for drug "rehabilitation" and expansion of voluntary services.

The authors of SB 1045 and SB 40 have repeatedly failed to reach out and consult with our community partners who are on the frontlines of providing care and support for homeless people with mental illness and substance abuse disorders. In fact, it is unclear who the authors have consulted, and, as a result, the City has no clear plan to implement this new scheme and does not have adequate facilities or services for expanding conservatorship.

We agree with, and strongly support, the Voluntary Services First coalition in opposing the implementation of SB 1045 and SB 40.

We respectfully urge you to vote No when File 181042 comes before the Rules Committee on May 13, 2019.

Sincerely,

Spencer Hudson
Indivisible SF
indivisible.spencer@gmail.com
(415) 373-8476