File No. 181042 Committee Item No. 2
Board Item No. _____

COMMITTEE/BOARD OF SUPERVISORS

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Board of Supervisors Meeting **Date** _____

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Completed by: Victor Young **Date** May 16, 2019
Completed by: _____ **Date** _____

[Health, Administrative Codes - Housing Conservatorships]

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

NOTE: **Unchanged Code text and uncodified text** are in plain Arial font.
Additions to Codes are in *single-underline italics Times New Roman font*.
Deletions to Codes are in ~~*strikethrough italics Times New Roman font*~~.
Board amendment additions are in double-underlined Arial font.
Board amendment deletions are in ~~strikethrough Arial font~~.
Asterisks (* * * *) indicate the omission of unchanged Code subsections or parts of tables.

Be it ordained by the People of the City and County of San Francisco:

Section 1. Article 41 of the Health Code is hereby amended by adding Division IV, consisting of Sections 4131 to 4135, to read as follows:

DIVISION IV: HOUSING CONSERVATORSHIPS

SEC. 4131. FINDINGS.

(a) State law establishes a procedure for the appointment of a conservator for a person who is determined to be gravely disabled as a result of a mental health disorder or an impairment by chronic alcoholism. Chapter 3 of Part 1 of Division 5 of the California Welfare and Institutions Code. State

law also establishes a procedure for the appointment of a conservator for individuals who are unable to properly provide for their needs for physical health, food, clothing and shelter, and for individuals who are substantially unable to manage their finances or resist fraud or undue influence. Division 4 of the California Probate Code.

(b) Notwithstanding State and City laws and programs designed to provide care for persons who are unable to care for themselves, some people fall through the cracks. For example, conservatorships under the Lanterman-Petris-Short Act, Chapter 3 of Part 1 of Division 5 of the California Welfare and Institutions Code ("LPS conservatorships"), do not take into consideration substance use disorders other than alcoholism. Therefore, individuals with a serious mental illness and co-occurring substance use disorder other than alcohol can be ineligible for LPS conservatorships, notwithstanding their mental health disorder and resulting needs.

(c) Individuals grappling with severe mental illness and a debilitating substance use disorder are often difficult to treat under existing short-term psychiatric programs and outpatient drug treatments available outside of conservatorship; these individuals often cycle in and out of treatment and have difficulty maintaining stable housing. As of the adoption of this Division IV, there is no avenue to conserve individuals in a supportive housing environment that provides wraparound services to those individuals.

(d) S.B. 1045 (Housing Conservatorship for Persons with Serious Mental Illness and Substance Use Disorders), codified at Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code, authorizes the counties of San Francisco, San Diego, and Los Angeles, to establish procedures for the appointment of a conservator for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, for the purpose of providing the least restrictive and most clinically appropriate alternative needed for the protection of the person.

(e) The Department of Public Health ("DPH"), the Human Services Agency ("HSA"), and the Department of Homelessness and Supportive Housing ("HSH") developed a plan ("the Housing Conservatorship Plan") to implement Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code, in consultation with representatives of disability rights advocacy groups, a provider of permanent supportive housing services, the county health department, law enforcement, labor unions, and staff from hospitals located in San Francisco. The Housing Conservatorship Plan is available in Board of Supervisors File No. _____.

(f) As required by S.B. 1045, as codified in subsection (b)(2) of Section 5450 of the California Welfare and Institutions Code, the Board of Supervisors held a public hearing on _____, where staff from DPH, HSA, and HSH presented the Housing Conservatorship Plan to the Board of Supervisors, and provided testimony concerning the available resources for the implementation of Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code. Based on materials and testimony presented at the hearing, the Board of Supervisors finds that the services set forth in subsection (b)(2) of Section 5450 of the California Welfare and Institutions Code are available in, at a minimum, sufficient quantity, resources, and funding levels to serve the identified population that the Board of Supervisors intends to serve in connection with the implementation of the Housing Conservatorship Program.

(g) The City finds that no voluntary mental health program serving adults, no children's mental health program, and no services or supports provided in conservatorships established pursuant to Division 4 (commencing with Section 1400) of the California Probate Code or conservatorships established pursuant to Chapter 3 (commencing with Section 5350) of the California Welfare and Institutions Code), including availability of conservators, will be reduced as a result of implementation of the Housing Conservatorship Program.

SEC. 4132. DEFINITIONS.

Terms not defined in this Division IV shall have the meaning attributed to them in Section 5452 of the California Welfare and Institutions Code, as may be amended from time to time.

"City" means the City and County of San Francisco.

SEC. 4133. AUTHORIZATION OF THE HOUSING CONSERVATORSHIP PROGRAM.

(a) The City authorizes the implementation of Chapter 5 (commencing with Section 5450) of Part 1 of Division 5 of the Welfare and Institutions Code through the establishment of the Housing Conservatorship Program, as provided in this Division IV.

(b) The purpose of the Housing Conservatorship Program is to provide the least restrictive and most clinically appropriate alternative needed for the protection of a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150 of the California Welfare and Institutions Code ("Section 5150"). If the court determines that the person needs to be moved from the person's current residence, the placement shall be in supportive community housing that provides wraparound services, such as onsite physical and behavioral health services, unless the court, with good cause, determines that such a placement is not sufficient for the protection of that person.

(c) The procedures for establishing, administering, and terminating a conservatorship under this Division IV shall be as set forth in Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code.

(d) The San Francisco Public Conservator is designated to provide conservatorship investigations as set forth in this Division IV, and those investigations shall comply with the requirements of Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code.

(e) The San Francisco Public Conservator may appoint a conservator of the person for a San Francisco resident who is incapable of caring for the person's own health and well-being due to a

serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150.

(f) A Housing Conservatorship pursuant to this Division IV shall not be established if a conservatorship or guardianship for the person exists under Division 4 (commencing with Section 1400) of the California Probate Code or under Chapter 3 (commencing with Section 5350) of the California Welfare and Institutions Code.

(g) The following professionals may recommend an evaluation for Housing Conservatorship to the Public Conservator upon a determination that a person in the professional's care is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150:

(1) The Sheriff, or the Sheriff's designee;

(2) The Director of the Department of Public Health, or the Director's designee;

(3) The Director of the Human Services Agency, or the Director's designee; or

(4) The professional person in charge of an agency providing comprehensive evaluation or a facility providing intensive treatment.

(h) If the Public Conservator, upon conducting an evaluation for Housing Conservatorship, finds that the person meets the criteria for Housing Conservatorship and the Housing Conservatorship is the least restrictive alternative, the officer shall petition the Superior Court of San Francisco to establish a Housing Conservatorship.

SEC. 4134. UNDERTAKING FOR THE GENERAL WELFARE.

In enacting and implementing this Division IV, the City is assuming an undertaking only to promote the general welfare. It is not assuming, nor is it imposing on its officers and employees, an obligation for breach of which it is liable in money damages to any person who claims that such breach proximately caused injury.

SEC. 4135. SUNSET DATE.

This Division IV shall expire by operation of law on December 31, 2023, unless the Legislature has amended Chapter 5 of Part 1 of Division 5 of the Welfare and Institutions Code to extend the authorization of local housing conservatorship programs beyond that date. If Chapter 5 is amended to extend beyond December 31, 2023, but to remain in effect only until a later date certain, on which date it is repealed, this Division IV shall expire by operation of law on that later date certain. In either event, upon expiration of this Division IV by operation of law, the City Attorney shall cause Division IV to be removed from the Health Code.

Section 2. Division III of Article 41 of the Health Code is hereby amended to revise Section 4121, to read as follows:

SEC. 4121. DESIGNATION OF CITY ATTORNEY.

The City Attorney is designated to represent the county in the following proceedings:

(a) Judicial proceedings authorized by Article 9 of Chapter 2 of Division 5 of the California Welfare and Institutions Code ("The Assisted Outpatient Treatment Demonstration Project Act of 2002"); ~~*and*~~

(b) ~~*Beginning January 1, 2019, j*~~*J*udicial proceedings authorized by Chapter 3 of Division 5 of the California Welfare and Institutions Code ("Conservatorship for Gravely Disabled Persons"); provided, however, that the City Attorney is not designated to represent the county in such proceedings where they concern a person who meets the definition of "gravely disabled" as set forth in subsection (h)(1)(B) of Section 5008 of the California Welfare and Institutions Code~~.~~*; and*

(c) Judicial proceedings authorized by Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code ("Housing Conservatorship for Persons with Serious Mental Illness and Substance Use Disorders").

Section 3. Chapter 5 of the Administrative Code is hereby amended by adding Article XXXVII, consisting of Sections 5.37-1 to 5.37-5, to read as follows:

ARTICLE XXXVII: HOUSING CONSERVATORSHIP WORKING GROUP

SEC. 5.37-1. ESTABLISHMENT OF WORKING GROUP.

There is hereby established the Housing Conservatorship Working Group (the "Working Group") of the City and County of San Francisco.

SEC. 5.37-2. MEMBERSHIP.

The Working Group shall be comprised of 12 members, appointed as follows:

(a) Seats 1 and 2 shall be held by representatives of disability rights advocacy groups, appointed by the Mayor and the Board of Supervisors, respectively.

(b) Seats 3 and 4 shall be held by representatives of labor unions, appointed by the Mayor and the Board of Supervisors, respectively.

(c) Seats 5 and 6 shall be held by representatives of organizations providing direct services to homeless individuals or families, appointed by the Mayor and the Board of Supervisors, respectively.

(d) Seat 7 shall be held by an employee of a hospital located in San Francisco with experience in mental health and substance use disorders, appointed by the Director of Health.

(e) Seat 8 shall be held by an employee of the Behavioral Health Services program of the Department of Public Health, appointed by the Director of Health.

(f) Seat 9 shall be held by an employee of the Department of Public Health, appointed by the Director of Health.

(g) Seat 10 shall be held by an employee of the Human Services Agency, appointed by the Director of the Human Services Agency.

(h) Seat 11 shall be held by an employee of the Department of Homelessness and Supportive Housing, appointed by the Director of the Department of Homelessness and Supportive Housing.

(i) Seat 12 shall be held by an employee of the San Francisco Police Department, appointed by the Chief of Police.

SEC. 5.37-3. ORGANIZATION AND TERMS OF OFFICE.

(a) Members of the Working Group shall serve at the pleasure of their respective appointing authorities, and may be removed by the appointing authority at any time.

(b) Appointing authorities shall make initial appointments to the Working Group by no later than 90 days after the effective date of this Article XXXVII.

(c) The Working Group shall hold its inaugural meeting not more than 30 days after a quorum of the Working Group, defined as a majority of seats, has been appointed.

(d) Members of the Working Group shall receive no compensation from the City, except that the members in Seats 8, 9, 10, 11, and 12 who are City employees may receive their respective City salaries for time spent working on the Working Group.

(e) Any member who misses three regular meetings of the Working Group within any 12-month period without the express approval of the Working Group at or before each missed meeting shall be deemed to have resigned from the Working Group 10 days after the third unapproved absence. The Working Group shall inform the appointing authority of any such resignation.

(f) The Department of Public Health shall provide administrative and clerical support for the Working Group, and the Controller's Office shall provide technical support and policy analysis for the

Working Group upon request. All City officials and agencies shall cooperate with the Working Group in the performance of its functions.

SEC. 5.37-4. DUTIES.

(a) The Working Group shall conduct an evaluation of the effectiveness of the implementation of Chapter 5 (commencing with Section 5450) of the California Welfare and Institutions Code ("Chapter 5") in addressing the needs of persons with serious mental illness and substance use disorders in the City. The evaluation shall include an assessment of the number and status of persons who have been conserved under Chapter 5, the effectiveness of these conservatorships in addressing the short- and long-term needs of those persons, and the impact of conservatorships established pursuant to Chapter 5 on existing conservatorships established pursuant to Division 4 (commencing with Section 1400) of the California Probate Code or Chapter 3 (commencing with Section 5350) of the California Welfare and Institutions Code, and on mental health programs provided by the City.

(b) The Working Group shall prepare and submit a preliminary report and a final report to the Mayor, the Board of Supervisors, and the Legislature on its findings and recommendations regarding the implementation of Chapter 5. The preliminary report shall be submitted to the Mayor and the Board of Supervisors by no later than November 1, 2020, and to the Legislature by no later than January 1, 2021, in compliance with Section 9795 of the California Government Code. The final report shall be submitted to the Mayor and the Board of Supervisors by no later than November 1, 2022, and to the Legislature by no later than January 1, 2023, in compliance with Section 9795 of the California Government Code.

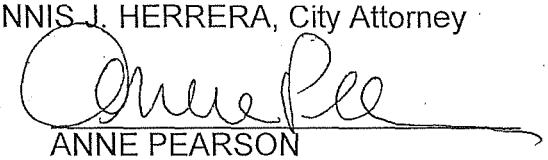
SEC. 5.37-5. SUNSET.

Unless the Board of Supervisors by ordinance extends the term of the Working Group, this Article XXXVII shall expire by operation of law, and the Working Group shall terminate, on December

31, 2023. In that event, after that date, the City Attorney shall cause this Article XXXVII to be removed from the Administrative Code.

Section 4. Effective Date. This ordinance shall become effective 30 days after enactment. Enactment occurs when the Mayor signs the ordinance, the Mayor returns the ordinance unsigned or does not sign the ordinance within ten days of receiving it, or the Board of Supervisors overrides the Mayor's veto of the ordinance.

APPROVED AS TO FORM:
DENNIS J. HERRERA, City Attorney

By: 
ANNE PEARSON
Deputy City Attorney

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FILE NO. 181042

LEGISLATIVE DIGEST

[Health, Administrative Codes - Housing Conservatorships]

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

Existing Law

Currently, state law establishes a procedure for the appointment of a conservator for a person who is determined to be gravely disabled as a result of a mental health disorder or an impairment by chronic alcoholism. State law also establishes a procedure for the appointment of a conservator for individuals who are unable to properly provide for their needs for physical health, food, clothing and shelter, and for individuals who are substantially unable to manage their finances or resist fraud or undue influence.

On September 27, 2018, Governor Brown signed into law S.B. 1045 (Housing Conservatorship for Persons with Serious Mental Illness and Substance Use Disorders), to be codified at Chapter 5 of Part 1 of Division 5 of the California Welfare and Institutions Code. S.B. 1045, which will be go into effect on January 1, 2019, authorizes the counties of San Francisco, San Diego, and Los Angeles, to establish procedures for the appointment of a conservator for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, for the purpose of providing the least restrictive and most clinically appropriate alternative needed for the protection of the person.

S.B. 1045 provides that before a county Board of Supervisors may authorize the establishment of a housing conservatorship program, local government departments must develop a plan to implement the program, in consultation with specified stakeholders, and must present the plan to the Board of Supervisors. In addition, after a public hearing and based on materials presented, the Board of Supervisors must make a finding that the county has enumerated services, including but not limited to supportive housing with wraparound services and adequate beds, outpatient mental health counseling, psychiatric and psychological services, and substance use disorder services, in sufficient quantity, resources, and funding levels to serve the identified population that the Board of Supervisors intends to serve. The Board of Supervisors must also make a finding that no voluntary mental health program serving adults, no children's mental health program, and no services or supports provided in other conservatorship programs, including the availability of conservators, may be reduced as a result of the implementation of the housing conservatorship program.

Once the Board of Supervisors has established a housing conservatorship program consistent with the requirements of S.B. 1045, a conservatorship of the person may be appointed for a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150. The procedures for establishing, administering, and terminating a housing conservatorship are set forth in state law.

The establishment of a housing conservatorship is subject to a finding by the court that the county has previously attempted by petition to obtain a court order authorizing assisted outpatient treatment ("AOT") and that the petition was denied or the AOT was insufficient to treat the person's mental illness, and AOT would be insufficient to treat the person in lieu of a housing conservatorship.

A person for whom a housing conservatorship is sought shall have a right to be represented by the public defender and to demand a jury trial to determine whether the person meets the criteria for the appointment of the conservator.

S.B. 1045 also requires the appointment of a working group that is charged with evaluating the effectiveness of the implementation of S.B. 1045 in addressing the needs of persons with serious mental illness and substance use disorders, and preparing reports to Legislature on its findings and recommendations regarding implementation.

Amendments to Current Law

The proposed ordinance would authorize the implementation of S.B. 1045 through the establishment of a Housing Conservatorship Program. The ordinance would designate the San Francisco Public Conservator as the agency that would provide conservatorship investigations and that may appoint a conservator of the person for San Francisco residents who are incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, as evidenced by frequent detention for evaluation and treatment pursuant to Section 5150.

The proposed ordinance would provide that the process for establishing, administering, and terminating a housing conservatorship would be as set forth in state law.

The ordinance would authorize the court to appoint the San Francisco Public Conservator as conservator if the court makes an express finding that it is necessary for the protection of the proposed conservatee and the granting of the conservatorship is the least restrictive alternative needed for the protection of the conservatee. Housing conservatorships will automatically terminate one year after the appointment of the conservator by the court, or shorter if ordered by the court.

The proposed ordinance would designate the City Attorney's office to represent the Public Conservator in housing conservatorship proceedings. It would also establish a Working

Group charged with evaluating the City's implementation of S.B. 1045. The Working Group would consist of 12 members, appointed by the Mayor, the Board of Supervisors, and specified department heads, and would be charged with preparing a preliminary report by November 2020, and a final report by November 2022.

Background Information

Notwithstanding State and City laws and programs designed to provide care for persons who are unable to care for themselves, some people fall through the cracks. For example, conservatorships under the Lanterman-Petris-Short Act, Chapter 3 of Part 1 of Division 5 of the California Welfare and Institutions Code ("LPS conservatorships"), do not take into consideration substance use disorders other than alcoholism. Therefore, individuals with a serious mental illness and co-occurring substance use disorder other than alcohol can be ineligible for LPS conservatorships, notwithstanding their mental health disorder and resulting needs.

Individuals grappling with severe mental illness and a debilitating substance use disorder are often difficult to treat under existing short-term psychiatric programs and outpatient drug treatments available outside of conservatorship; these individuals often cycle in and out of treatment and have difficulty maintaining stable housing. Currently, there is no avenue to conserve individuals in a supportive housing environment that provides wraparound services to those individuals.

As part of the legislative process, the Board of Supervisors will hold a public hearing at which City departments will present a Housing Conservatorship Plan and other information relating to the available resources for the implementation of S.B. 1045.

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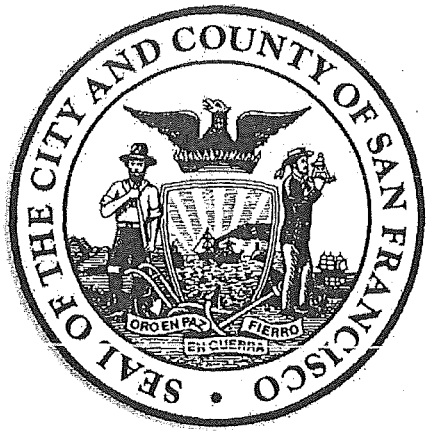


HOUSING CONSERVATORSHIP PILOT

An Implementation Plan for SB 1045 in the City and County of San Francisco

This report has been prepared by the San Francisco Department of Public Health, San Francisco Department of Homelessness and Supportive Housing, and the Department of Aging and Adult Services/ Office of the Public Conservator.

Introduction

Governor Brown signed SB 1045 on September 27, 2018, which enables the Board of Supervisors in the City and County of San Francisco to implement a program to provide conservatorship (Housing Conservatorship) for individuals incapable of caring for their own health and well-being due to serious mental illness and substance use disorder as long as it is the least restrictive and most clinically appropriate intervention needed for the protection of the person.

The Housing Conservatorship model was created to serve a population of individuals with serious mental illness and serious substance use disorder who are currently (1) ineligible for other kinds of conservatorship and (2) whose needs are unmet by Assisted Outpatient Treatment (AOT) due to the specific nature of their diagnoses. Additionally, Housing Conservatorship requires the provision of Permanent Supportive Housing in order to pursue conservatorship, which is a necessary yet novel component to addressing the acute needs of this population, which other similar programs do not require.

This program would give the City Attorney the ability to petition the courts on behalf of the Office of the Public Conservator to place an individual into conservatorship only if they meet the necessary criteria.

SB 1045 requires that the City and County develop a plan in consultation with representatives from disability rights advocacy groups, a provider of permanent supportive housing services, the county health department, law enforcement, labor unions, and staff from hospitals located in the city and county prior to implementation.

In addition to gathering input from community stakeholders, SB 1045 requires that the implementation plan discuss the availability of resources necessary to implement the new conservatorship program. Specifically, the plan must demonstrate that necessary services, resources and funding levels are available in sufficient quantity, to serve the identified population.

The services required for implementation are: supportive community housing; properly trained public conservators; outpatient mental health counseling; coordination and access to medications; psychiatric and psychological services; substance use disorder services; vocational rehabilitation; veterans' services; family support and consultation services; complete service planning and delivery process; and individual personal service plans.

The City convened a working group that met on October 26, 2018, Dec 7, 2018, and January 18, 2019 with representatives from disability rights advocacy groups, providers of permanent supportive housing services, the county health department, law enforcement, labor unions, public

defenders, hospital staff, local business owners, and others. This report was developed in consultation with the parties required by SB 1045 and many additional community partners. It contains information on the plan to implement the new conservatorship program and the resources available to implement the plan.

Elements Required for 1045 Conservatorship and Subject Population

SB 1045 allows the City and County of San Francisco to appoint a conservator for a person for whom it has been determined through clinical assessment is incapable of caring for their own health and well-being due to a serious mental illness and substance use disorder, as evidenced by at least eight involuntary detentions in the preceding 12 months for evaluation and treatment pursuant to Section 5150.

Prior to appointing a conservator, the court must make an express finding that conservatorship is necessary for the protection of the proposed conservatee and the granting of the conservatorship is the least restrictive alternative needed for their protection.

The San Francisco Department of Public Health (SFDPH) identified 55 individuals in the city who potentially meet the criteria for SB 1045. These individuals had eight or more 5150 holds in Psychiatric Emergency Services (PES) in San Francisco which resulted in a clinical assessment at a hospital within a twelve month period looking back two years. Additionally, they have identified 48 other individuals who have six or seven 5150 holds and may become eligible in the future.

The individuals who have been identified as potentially eligible for a Housing Conservatorship already receive crisis-level interventions several times a year. As a result, this population is already voluntarily able to access all of the services required by SB 1045 outside the context of Housing Conservatorship; however, due to symptoms associated with their acute mental health and substance use disorder, these individuals have been unwilling to engage in voluntary services. If any one of these individuals were to engage in appropriate services voluntarily, they would not be eligible for conservatorship nor would the city petition a court to conserve. As a result, Housing Conservatorships would be reserved for a very small population of individuals who are in crisis and who have repeatedly refused voluntary help. This new model presents a unique opportunity to deliver needed services to a pre-existing population who otherwise are deteriorating on our streets. Eligible individuals will receive direct oversight and case management from the Office of the Public Conservator in conjunction with additional community-based and City providers

SB 1045 requires that the Office of the Public Conservator explore all possible avenues for treatment and intervention prior to seeking a Housing Conservatorship. As a result, even after meeting the threshold criteria, it may not necessarily mean that a Housing Conservatorship is the most appropriate and least restrictive (as required by law) intervention for any specific individual.

Referrals for Housing Conservatorships will be accepted and coordinated through the Assisted Outpatient Treatment (AOT) program that SFDPH Behavioral Health Services operates. All referrals will be evaluated for appropriateness to the Assisted Outpatient Treatment program, a statutory pre-requisite for a subsequent referral to the Housing Conservatorship program.

When the court determines that AOT is insufficient to assist a client, or if the court denies a petition for court ordered outpatient treatment, a Housing Conservatorship will be considered as an intervention. The AOT program and the Office of the Public Conservator will coordinate appropriate referrals to the Housing Conservatorship program through regular meetings, and as-needed case level communication.

At the time of this report's drafting, there is a follow-up bill pending in the State Legislature. That bill, Senate Bill 40 authored by Senator Wiener, is intended to clean up ambiguity in the original bill relating to AOT. The new bill, if passed by the Legislature and signed by the Governor, will clarify that any individual who is eligible statutorily for AOT must first go through that program. But for those who do not meet the requirements of that program, a court must make a finding to that effect before considering granting a petition for a Housing Conservatorship.

Services Required in Sufficient Quantities, Resources and Funding Levels:

The San Francisco Department of Public Health (SFDPH) provides services to a wide range of individuals, many of whom access services through SFDPH's Behavioral Health Services to address substance use disorder and mental health treatment needs. Services range from prevention and early intervention, outpatient treatment, residential treatment, crisis programs, and acute services. Individuals who access care through the SFDPH represent a diverse population with varying levels of need. The SFDPH is committed to utilizing a creative evidence-based approach so that each person is able to reside in the least restrictive clinically appropriate setting with the support needed to thrive.

The population that SB1045 aims to reach has been and will continue to be a priority for SFDPH's Behavioral Health Services and as such are not a new population of individuals in need of services. These individuals have highly acute mental health and substance use disorder needs and have been unsuccessful in otherwise engaging in voluntary care for behavioral health services. As a result, they cycle in and out of crisis services regularly. Through a Housing Conservatorship, these individuals will access coordinated, wrap-around supportive services specifically tailored to help the needs of each individual. Services for this population may include outpatient mental health counseling, coordination and access to medications, psychiatric and psychological services, substance use disorder services, vocational rehabilitation, family support and consultation, and service planning.

In fiscal year 17/18, SFDPH's Behavioral Health Services provided 6,596 unduplicated individuals with substance use disorder services and 21,907 unduplicated individuals with mental

health services. In Fiscal Year 18/19, the overall budget for Behavioral Health Services is approximately $394 million ($312 million for mental health services and $82 million for substance use disorder services) and funds city-operated clinics and community based organizations (107 contracts with 87 vendors). In order to support adults in our system of care, Behavioral Health Services has 12 city-operated mental health programs and funds roughly 60 substance use disorder programs and 122 mental health community based programs. Many of the individuals who meet the threshold requirements for SB 1045 are included in the statistics above, and so services are already being provided, yet have been ultimately unsuccessful in providing the necessary stabilization as a result of the voluntary, and therefore unsustained, nature of these services.

The SFDPH and Department of Aging and Adult Services (DAAS) are committed to closely collaborating on this effort to ensure patients receive comprehensive and individualized care. These departments will also closely partner to provide educational opportunities for potential referral entities to ensure that this tool is utilized in an effective and thoughtful manner.

In order to implement a Housing Conservatorship program under SB1045, the City and County of San Francisco must demonstrate that it has the following required services in sufficient quantities, resources, and funding to serve the identified population.

Supportive Community Housing

The Department of Homelessness and Supportive Housing is prepared to provide Permanent Supportive Housing to homeless individuals in the Housing Conservatorship program who can self- care, which is a point in the recovery process after medical stabilization has been completed, either through the acceptance of supportive services or independently. Connection to the Permanent Supportive Housing will be ongoing and will continue after the termination of the conservatorship. The Department has adequate capacity in its existing PSH portfolio to accommodate the anticipated population of individuals for whom a Housing Conservatorship is most appropriate.

For those individuals who cannot self- care, either through the acceptance of supportive services or independently, the Office of the Public Conservator will recommend to the court, the most appropriate and least restrictive placement in a licensed care facility. This recommendation will be determined through a comprehensive clinical assessment carried out in collaboration with the psychiatric and clinical care team. The Department of Public Health will provide the court-authorized placement as long as it continues to be clinically appropriate.

The Department of Homelessness and Supportive Housing has approximately 7,700 units of PSH in its portfolio with approximately 800 units turning over each year. Of these 800 available placements, approximately 200 are in buildings with the highest level of supportive services.

Units with high levels of supportive services are ideal for those entering the Housing Conservatorship program. Individuals who qualify for Housing Conservatorship are among our most vulnerable homeless neighbors and already receive high priority for PSH under the framework established in the Adult Coordinated Entry System. Housing Conservatorship will not expand the pool of people experiencing homelessness that need PSH, but the program is a new tool to better connect the most vulnerable individuals in our homeless population with the housing and services they need.

Properly Trained Public Conservators

The DAAS operates San Francisco's Office of the Public Conservator. This program is staffed by fourteen Deputy Conservators, two supervising Deputy Conservators, and operate under the oversight of one Manager. The Office of the Public Conservator currently serves approximately 556 individuals. The program anticipates that current staffing levels will be sufficient to provide effective services to those clients that SFDPH has identified as potentially eligible for a Housing Conservatorship without reducing services to other populations. The population potentially eligible for a Housing Conservatorship is primarily composed of individuals who already frequently receive crisis-level intervention several times a year. Additionally, the flow of this population into and through Housing Conservatorship would be only a very small number of individuals at any one point in time.

The minimum qualifications required by the classification for the Deputy Conservators are rigorous in order to ensure that staff have the necessary training and educational formation to provide high quality services to vulnerable populations. All Deputy Conservators are required to have at least a Master's degree in social work or a two-year counseling degree. Additionally, the minimum qualifications for the position require deputy conservators to possess a valid clinical license through California's Board of Behavioral Sciences (BBS), or proof of registration as a clinical intern working towards licensure under the supervision of a fully licensed clinician. Acceptable licenses include Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), Professional Clinical Counselor (LPCC) as well as the associated intern status for each degree.

In addition to these minimum qualifications, Deputy Conservators receive comprehensive training from the program's Supervising Deputy Conservators under the oversight of the program's Manager. They receive training regarding assessment and evaluation specific to the concepts of grave disability and determining appropriate level of care for adults with serious mental illness. As required by the BBS, Deputy Conservators receive training on ethics as well as critical legal concepts such as conflict of interest and mandatory abuse reporting requirements. Additionally, Deputy Conservators receive intensive training regarding the laws and regulations pertaining to the LPS Act that is part of the Welfare and Institutions Code.

In close consultation with the City Attorney, the program's Manager will provide Deputy Conservators with training related to the new regulations that pertain to the Housing Conservatorship law. Deputy Conservators will receive training regarding the new criteria for conservatorships as well as the due process rights that are provided to conservatees.

Outpatient Mental Health Counseling

Behavioral Health Services provides a wide range of specialty mental health outpatient services for individuals that have mental health needs and are experiencing a significant impairment in an important area of life functioning. These services are provided by a culturally diverse network of community behavioral health programs, clinics, and private psychiatrists, psychologists, and therapists. Services include:

Engagement Specialists: Engagement specialists provide a range of services to individuals in the community who may not otherwise be connected to care. Specialists are generally individuals who identify as having lived experience and provide opportunities to develop relationships needed to support engagement in more formalized service locations (e.g., clinic). This program launched in Fiscal Year 17/18 and continues to be vital in supporting individuals with behavioral health needs who are experiencing homelessness.

Outpatient Mental Health Clinics: Civil service clinics and community-based organizations provide outpatient, generally clinic-based, rehabilitation and recovery services to a wide range of individuals with mental health services needs and their families. These clinics offer drop in hours for individuals seeking care to be assessed for services and receive immediate support while awaiting linkage to a long term provider.

Intensive Case Management/Full Service Partnership: This level of care provides an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with serious mental illness (SMI) to lead independent, meaningful, and productive lives. These services provide intensive support, with a lower staff to client ratio, to individuals who have significant needs (e.g., involvement in the criminal justice system, experiencing homelessness, considered to be high risk of needing acute psychiatric care). Services include individual and group therapy, peer and family support, and medication services.

Given the level of need anticipated for individuals that will be served through the Housing Conservatorship program, the SFDPH anticipates utilizing intensive case management services for this population and would prioritize them into care similarly to other individuals with equivalent service needs. The population eligible for Housing Conservatorship is primarily composed of individuals who already receive crisis-level intervention several times a year.

Additionally, the flow of this population into and through the system means individuals who qualify for Housing Conservatorship would enter the program incrementally.

Many of the individuals eligible for a Housing Conservatorship already receive treatment resources, albeit in an often interrupted, inefficient, and therefore suboptimal manner from the perspective of individual outcomes As such, serving this population through Housing Conservatorship will not result in reduction or redistribution of services overall but will result in services better and more efficiently offered to individuals. These services to be provided to individuals through the provisions of a Housing Conservatorship include family and peer support, individual and group therapy, medication management, and a low provider-to-client ratio. This level of comprehensive and holistic care will support stabilization in the least restrictive clinically appropriate setting and transition to long term outpatient mental health services.

In addition to the above services, the SFDPH funds a Comprehensive Crisis Clinic for individuals in need of acute services, as well as a Behavioral Health Access Center which provides centralized in-person and phone support for linkage to services. Additionally, individuals who are consumers of behavioral health services are also eligible to receive additional support through the Peer Wellness Center, which is an early engagement center for adults seeking peer-based counseling services and peer-led activities. Not all of these services will be appropriate for every individual in the Housing Conservatorship program, but they will be able to access them as needed.

Coordination and Access to Medications

Community Behavioral Health Services-Pharmacy Services within the SFDPH works closely with the city and contracted service providers to provide a high level of care and ensure continuous access to medications. Pharmacy Services can currently meet the needs of the Housing Conservatorship population because the population eligible for Housing Conservatorship is primarily comprised of individuals who already frequently receive crisis-level intervention including access to medication several times a year. Additionally, the flow of this population into and through the system means individuals who qualify for Housing Conservatorship would enter the program incrementally.

Pharmacy services provides buprenorphine for Integrated Buprenorphine Intervention Services (IBIS) clients, methadone maintenance for Office-Based Opioid Treatment (OBOT) clients, ambulatory alcohol detoxification medications for Treatment Access Program clients, naloxone for opiate overdose prevention, specialty behavioral health medication packaging, and serves as a pharmacy safety net for all BHS clients.

The City runs clinics and employs service providers that provide outpatient mental health services staff who are able to prescribe and administer medications. The medical team at each clinic partners closely with the assigned case manager to coordinate care and ensure that there are not delays in accessing and/or continuing medications.

In the event that an individual is experiencing a psychiatric emergency, they are able to access same day services at a community based crisis clinic to support stabilization and referral back to their treatment team or referral to ongoing services. The SFDPH also funds a Street Medicine team that provides low threshold medical and psychiatric support to individuals experiencing homelessness who have complex service needs. This team closely partners with community based treatment providers to provide holistic and comprehensive care.

Psychiatric and Psychological Services

The SFDPH provides a range of treatment options at varying levels of care to meet the breadth of needs of residents with mental health and substance use disorder treatment needs. These include:

Crisis Stabilization: Crisis Services are a continuum of services that are provided to individuals experiencing a psychiatric emergency. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment. This level of care includes Psychiatric Emergency Services, Acute Diversion Units, and Psychiatric Urgent Care.

Acute Psychiatric Care: Acute inpatient psychiatric services provide high-intensity, acute psychiatric services 24 hours a day for individuals in acute psychiatric distress and experiencing acute psychiatric symptoms and/or at risk of harm to self or others.

Withdrawal Management and Respite: These programs provide acute and post-acute medical care for individuals who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. They provide short-term residential care that allows individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. This level of care includes Medical Respite, Sobering Center, Medical Detox, Social Detox, and Behavioral Health Respite Navigation Center.

Locked Residential Treatment: These programs are 24-hour locked facilities providing intensive diagnostic evaluation and treatment services for severely impaired residents suffering from a psychiatric illness. This level of care includes Locked Sub-acute, Psychiatric Skilled Nursing Facility, and State Hospital.

Open Residential Treatment: A residential treatment facility is a live-in health care facility providing therapy for substance use disorder, mental illness, or other behavioral problems. Some residential treatment facilities specialize in only one illness -- substance

use disorder -- while others treat people with a variety of diagnoses or dual diagnosis of substance use disorder and a psychiatric diagnosis. This level of care includes Dual Diagnosis, Substance Use Disorder, and Mental Health placements.

Transitional Housing: Transitional Housing provides people with significant barriers to housing stability with a place to live and intensive social services while they work toward self-sufficiency and housing stability. This level of care includes Sober Living Environment, Cooperative Living, Support Hotel, Stabilization Rooms, and Shelter.

The SFDPH routinely looks for opportunities to increase capacity for services in order to meet the dynamic needs of individuals served by our system of care. This included innovative approaches such as recent opening of locked residential treatment beds at the Healing Center, creating a low threshold respite on the grounds of Zuckerberg San Francisco General Hospital, and using a grant from the Board of State and Community Corrections to increase substance use disorder residential treatment and social detox capacity.

The SFDPH works closely with providers to determine the appropriate level of residential treatment and prioritizes placements into these levels of care for our most vulnerable residents. The population eligible for Housing Conservatorship is primarily comprised of individuals who already frequently receive crisis-level intervention including psychiatric and psychological services several times a year. Additionally, the flow of this population into and through the system means individuals who qualify for Housing Conservatorship would enter the program incrementally. Given the significant needs of individuals who qualify for Housing Conservatorship and their current level of frequent contacts with crisis services, they would be prioritized into the clinically appropriate level of care in a similar manner as other individuals with acute needs and can meet the needs of this population without reducing or diverting services.

Substance Use Disorder Services

Treatment offered through Behavioral Health Services is integrated, ensuring that individuals with co-occurring mental health and substance use disorder treatment needs receive comprehensive support. Addiction treatment medications are offered at all levels of care, including primary care and street medicine. The SFDPH supports a wide range of services to support individuals who need specialized substance use disorder treatment services. In addition to the residential and withdrawal management ("detox") support services listed in the above section, this also includes:

Opioid Treatment Programs (OTP): These programs offer same day admission to a structured, outpatient treatment that often includes daily medication visits with a dispensing nurse. Methadone, buprenorphine ("Suboxone"), and alcohol medications are available in the OTPs, along with individual and group counseling. Some of the OTPs are able to support HIV and Hepatitis C medication administration as well.

Outpatient Treatment: Services are offered in two levels of care, outpatient and intensive outpatient. Rehabilitation and recovery services are offered to a wide range of individuals and may include individual, group and peer support.

In response to a nationwide epidemic, the SFDPH has also invested in supporting increased access to opioid addiction treatment. The fiscal year 17/18 and 18/19 budget includes $6.0 million over two years to expand the Street Medicine Team, and its innovative buprenorphine program to support serving more than 250 individuals. This investment will fund 10 new health care professionals– a mix that includes physicians, nurses, and social workers.

These services will be accessible to individuals served through the Housing Conservatorship program. Given the anticipated significant substance use disorder treatment needs of this population, as well as the frequent crisis-level contact these individuals currently have with the system, they would be prioritized into the clinically-appropriate services in a similar manner as other individuals with comparable service needs. The population eligible for Housing Conservatorship is primarily comprised of individuals who already frequently receive crisis-level intervention including substance use disorder services several times a year. Additionally, the flow of this population into and through the system means individuals who qualify for Housing Conservatorship would enter the program incrementally; as a result, the Housing Conservatorship population can be served without reducing or redistributing services.

Vocational Rehabilitation

The SFDPH incorporates vocational services within its mental health programming through Mental Health Services Act funding. These vocational services ensure that individuals with serious mental illness and co-occurring disorders are able to secure meaningful, long term employment. Research shows that supported employment programs help individuals with mental illness achieve and sustain recovery.

In collaboration with The California Department of Rehabilitation, the San Francisco Department of Public Health provides for various training and employment support programs to meet the current labor market trends and employment skill-sets necessary to succeed in the competitive workforce. These vocational programs and services include vocational skill development and training, career/situational assessments, vocational planning and counseling, service coordination, direct job placement, ongoing job coaching, and job retention services.

Examples of these services include collaborating with the Department of Rehabilitation to provide vocational assessments, the development of an Individualized Plan for Employment, vocational planning and job coaching, vocational training, sheltered workshops, job placement, and job retention services. Additionally the First Impressions program offers training in basic construction and remodeling skills, such as painting and patching walls, ceilings, and doors;

changing/applying window dressings; installing and disposing of furniture and accessories; building furniture; cleaning and repairing flooring; hanging décor; and minor landscaping. Vocational services offered by this program include vocational assessments, vocational planning and job coaching, vocational training and workshops, job placement, and job retention services.

Service plans developed in collaboration with participants through Housing Conservatorship may include Vocational Rehabilitation as a distal goal for recovery as appropriate for the individual. Treatment providers will work closely with participants to identify vocational interests and support linkage to employment specialists. To the extent that there are individuals who enter the Housing Conservatorship program who are not accessing these services, the existing programs have the capacity to meet the additional demand.

Veterans' Services

DAAS operates San Francisco's County Veterans Service Office (CVSO). This program assists veterans and their dependents to apply for benefits and entitlements that they may be eligible to receive. The program is sufficiently staffed by one Veterans Services Representative Supervisor and five Veterans Services Representatives. All staff are trained and accredited Veterans Claims Representatives that can carry out a full Veterans Administration (VA) Benefits Review.

In addition to identifying and applying for benefits that a veteran and/or their dependents may be eligible to receive, the CVSO staff will case manage the application for benefits during the VA review process. As needed, CVSO staff will advocate on behalf of veterans and/or their dependents with the VA to ensure that their application is given full consideration. Because the population eligible for Housing Conservatorship already receives a high level of care from the city, veterans who are eligible for Housing Conservatorship may already receive many of these services. To the extent that there are veterans who enter the Housing Conservatorship program who are not accessing these services, the existing programs have the capacity to meet the additional demand.

Family support and consultation services

With the understanding that individuals benefit from strong family support during their journey to recovery and wellness, the SFDPH will prioritize family engagement when planning and implementing SB1045. Consequently, as part of the process, families will be engaged and offered education and support, including information about eligibility, benefits, limitations, and opportunities of the program. This support is critical, because investing time to educate family members on behavioral health needs, what it means to have behavioral health needs, and how to strengthen participants' support systems can result in improved outcomes for program participants.

Given the close work with Assisted Outpatient Treatment (AOT), which employs two team members to provide peer and family support, we anticipate that family members will be able to receive support and consultation services. Additional staff members include four clinicians, one psychologist, and one manager. As previously discussed, as individuals are connected to intensive case management services, as well as a Public Conservator, these treatment providers will be able to offer additional resources as they provide support to their loved ones. Because the population eligible for Housing Conservatorship already receives a high level of care from the city, individuals who are eligible for Housing Conservatorship may already receive family support services. To the extent that there are individuals who enter the Housing Conservatorship program who are not accessing these services, the existing programs have the capacity to meet the additional demand.

Complete Service Planning and Delivery Process/Plans and Services

The Office of the Public Conservator will work closely with city partners including Behavioral Health Services and the Department of Public Health as well as community-based organizations to develop individualized, tailored service plans for all Housing Conservatorship clients. Complete service planning is a function of the city's ability to provide properly trained public conservators and other required services. As the other services are not resource constrained, neither is the city's ability to provide complete service planning for individuals in the Housing Conservatorship program.

The service planning and delivery process for all clients will include the following:

- Assessments and evaluations of the needs of individual clients will consider cultural, linguistic, gender, sexual orientation, gender identify, age, and special needs of minorities, other forms of disability, and those based on any characteristic listed or defined in Section 11135 of the Government Code in the target populations. Whenever possible, services will be provided by bilingual and bicultural staff and/or with the support of high-quality translators to reduce barriers to mental health services as a result of having limited-English-speaking ability or cultural differences;

- The needs of clients with physical disabilities will be considered and accommodated during the service planning and delivery process. This may include the need to provide appropriate transportation services, durable medical equipment, written materials in accessible formats, and/or the provision of services provided in the client's place of residence, as well as any other reasonable service adaptation that might be required;

- The special needs of older adult clients will be considered and addressed during the service planning and delivery process. This may include the need to accommodate for physical disabilities, provide tailored transportation services, or the need for services to be provided in the client's place of residence. Service providers will be trained to meet

the specialized needs of older adult populations;

- As appropriate, specialized services will be provided for clients that are found to need family support and consultation services, parenting support and consultation services, and peer support or self-help group support. Such services may be accessed through appropriate referrals and connections to community based organizations as well as City departments;
- Clients will be engaged to participate actively, and whenever possible, to direct their own service and recovery process. Services that are provided to clients will employ psychosocial rehabilitation and recovery principles;

- Psychiatric and psychological services that are provided will be integrated with other services to ensure the full collaboration of all service providers that are contributing to the individualized plan;

- Services that are provided to clients will take into account the special needs of women from diverse cultural and socioeconomic backgrounds;

- Provision for housing for clients that is immediate, transitional, permanent, or all of these; and

- Services that are provided will take into account the special needs of lesbian, gay, bisexual, and transgender (LGBT) individuals and by providers that have completed LGBTQ sensitivity training.

Individual Personal Service Plans

The Office of the Public Conservator will work closely with city partners such as Behavioral Health Services and the Department of Public Health and community based organizations to develop individualized, tailored service plans for all Housing Conservatorship clients. The Office of the Public Conservator is responsible for overseeing and coordinating individual personal service plans for all conservatees. The provision of individual personal service plans is a function of the city's ability to provide properly trained public conservators and other required services. As the other services are not resource constrained, neither is the city's ability to provide individual personal service plans for individuals in the Housing Conservatorship program.

The individual personal services plan ensures that a person subject to conservatorship pursuant to this chapter receives age-appropriate, gender-appropriate, disability-appropriate, and culturally appropriate services, to the extent feasible and when appropriate, that are designed to enable those persons to do all of the following:

- Live in the most independent, least restrictive clinically appropriate housing feasible in the local community, and, for clients with children, to live in a supportive housing

environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate;
- Engage in the highest level of work or productive activity appropriate to their abilities and experience;
- Create and maintain a support system consisting of friends, family, and participation in community activities;
- Access an appropriate level of academic education or vocational training;
- Obtain an adequate income;
- Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives;
- Access necessary physical health benefits and care and maintain the best possible physical health; and
- Reduce or eliminate the distress caused by the symptoms of mental illness.

Civil Liberties/Patient Protection

This report is meant to demonstrate that the City and County of San Francisco has the capacity to implement and administer the Housing Conservatorship program authorized by SB 1045. The program will focus on the critical acute needs of a specific population of individuals who have a demonstrated history of serious mental illness and substance use disorder. The City also recognizes that there are other important considerations about how this program should be implemented. In order to implement this program, SB 1045 requires that the City and County of San Francisco implement several levels of safeguards to preserve the rights of individuals who are in or are being considered for the Housing Conservatorship program.

In order to implement this program and place individuals into a Housing Conservatorship, the program must be the least restrictive clinically appropriate option for a person whom it has been determined through clinical assessment to be incapable of caring for their own health and well-being due to a serious mental illness and substance use disorder. In order to guarantee Housing Conservatorship is the least restrictive clinically appropriate solution, individuals have the right to a public defender and a jury trial at the time the City petitions the court for Housing Conservatorship. The officer investigating the Housing Conservatorship must evaluate all available alternatives including Assisted Outpatient Treatment and provide a written report to the court. In the event that an individual is placed in Housing Conservatorship, that individual may contest the conservatorship at any time. Housing Conservatorship automatically terminates after one year, and the city must petition the courts to extend it. Subsequent petitions will have to continue to demonstrate that this is the least restrictive clinically appropriate treatment option.

Additionally, the City must establish a working group to evaluate the effectiveness of the program. The working group shall be comprised of representatives of disability rights advocacy groups, the county mental health department, the county health department, the county social services department, law enforcement, labor unions, staff from hospitals located in the county or

the city and county, and, if one exists, the county department of housing and homeless services. This working group will be created after the city and county opts into the SB 1045 program.

The City can only propose Housing Conservatorship if it can provide all of the required services listed in this report and in SB 1045. While this report demonstrates that the City currently has the capacity to administer the program effectively, it will have to continue to demonstrate that capacity to the working group and to the courts in order to continue to seek Housing Conservatorships.

Conclusion

Housing Conservatorship is a new tool to address the needs of a unique and specific preexisting population whose acute care needs are currently unmet and for whom stabilization has been unsuccessful. The aim of the Housing Conservatorship program is to enhance the health and well-being of a specific subset of the city's most vulnerable adult population by providing them with treatment and comprehensive services including permanent supportive housing.

SB1045 – HOUSING
CONSERVATORSHIP OVERVIEW

Hearing and Ordinance
Files 190372 and 181042

Presentation Outline

I. Introduction

II. A Case Story

III. Existing Care Options

IV. Senate Bill 1045
- ❑Housing Conservatorship Pilot
- ❑Population
- ❑Process
- ❑Connection to Housing
- ❑Key Provisions
- ❑Services and Implementation

V. Behavioral Health Services

VI. Testimonial

VII. Questions

INTRODUCTION

Issue

- The landscape of need has changed.
- Current methamphetamine and opioid epidemic.
- Vulnerable individuals who are unable to care for themselves due to a combination of serious mental health AND substance use disorder that cycle in and out of crisis.
- Ineligible for traditional involuntary or court ordered treatment options.
- Most are chronically homeless.
- Absent intervention, individuals may die on our streets.
- San Francisco has a history of innovation to expand and adapt our care to meet the needs of our population.
- SB 1045 provides San Francisco a narrow tool to care for these vulnerable individuals on our streets that have severe addictions and are mentally ill through a time limited Housing Conservatorship.

Our Team

1. ***Behavioral Health Services @ DPH*** provides mental health and substance use prevention, early intervention, and treatment services.

2. **The *Office of the Public Conservator @ DAAS*** is responsible for overseeing the psychiatric care of San Francisco residents who are on a conservatorship and who have been found by the court unable or unwilling to accept voluntary treatment.

Conservatorship Terms

LPS – Lanterman-Petris-Short Act – The conservatorship law from 1968 that was named after the bill's authors.

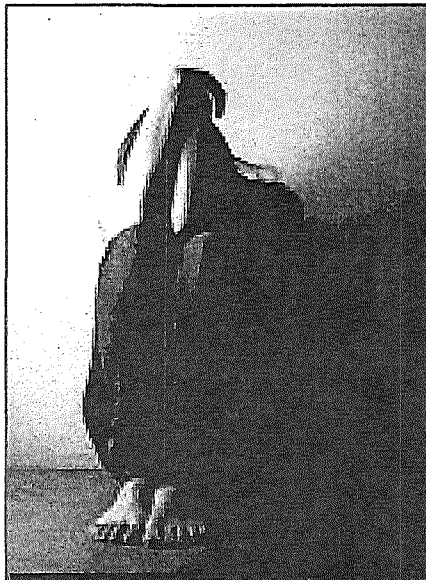
Mental Health Conservatorships – Another way to refer to LPS conservatorships that are overseen by the Office of the Public Conservator.

Public Guardian – The program that oversees probate conservatorships for adults with cognitive impairments and other types of serious functional disabilities.

MELANIE

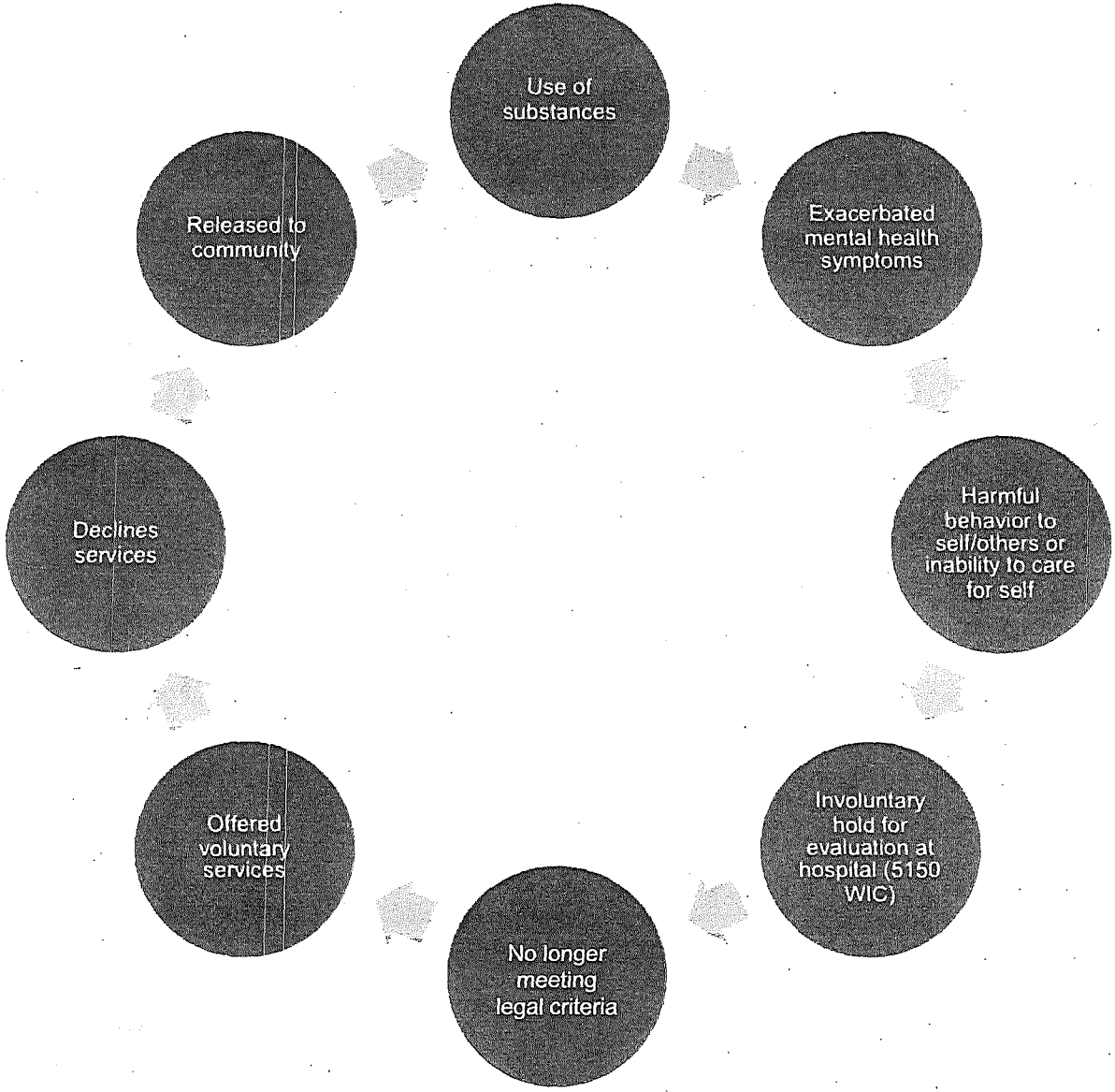
A Case Story

Melanie



- Individual with serious mental illness and substance use disorder.
- Frequent medical and psychiatric crisis incidents
  - Often running in and out of traffic while under the influence of substances
  - Serious infections and wounds
  - Psychosis
- Ten 5150 holds in Psychiatric Emergency Services (PES) in one year
- Presents as stable when no longer under the influence of substances
- Declines voluntary treatment services, cycles back in emergency room days later
- Without treatment, she will continue to get worse and is at risk of dying on our streets

Cycle of Acute Mental Illness and Substance Use



Gap in Existing Laws

- Cycle in and out of crisis services, getting progressively worse.
- Co-diagnosis of substance use disorder and mental health; unable to care for own health and well being.
- But do not meet the grave disability standard, which requires inability to care for basic needs (i.e., food, shelter and clothing) as a "result of a mental disorder".

EXISTING CARE OPTIONS

For Individuals in Crisis

Option #1: Assisted Outpatient Treatment "Laura's Law"

Adopted by board of Supervisors in 2014 and launched in November 2015, Assisted Outpatient Treatment is a court ordered program for individual with severe mental illness, ***not substance use disorders.***

Must meet strict legal eligibility:

a) **Have two admissions of inpatient psychiatric hospitalization or received mental health services while incarcerated; or**

b) **Have been involved in threats or acts of violent behavior towards themselves or another.**

What is the goal of AOT?

- Designed to assist individuals who are not engaged in treatment, are deteriorating, and have a history of poor treatment compliance.
- Provides community based treatment plan.

Why doesn't Melanie qualify?

- Does not meet legal threshold for **inpatient** hospitalization.
  - Mental illness is no longer acute when not under the influence of substances.
  - No contact with jail for mental health services.
  - Does not exhibit serious violent behavior.

Option #2: LPS Conservatorship

A legal procedure through which the Superior Court appoints a conservator to authorize psychiatric treatment of **a person who meets legal definition of grave disability by reason of a mental illness.** Established in the California Welfare and Institutions Code (WIC).

- Does not account for the effects of psychoactive substances other than alcohol.
- Under existing statute, "Grave Disability" is the legal basis for involuntary commitment and refers to the inability of an adult to provide for their basic needs (food, clothing, shelter) due to impairment by mental illness or chronic alcoholism.

What is the goal of LPS?

- Move individuals who are considered gravely disabled towards recovery and wellness in the least restrictive setting possible
- Connect individuals to a range of psychiatric and supportive services that promote health, recovery and well-being.

Why doesn't Melanie qualify?

- By strict definition, she is not considered gravely disabled.
  - She is able to provide a plan for obtaining food, clothing and shelter once she is not under the influence of psychoactive substances.
  - Treating psychiatric team does not have the legal basis to hospitalize her involuntarily.

HOUSING CONSERVATORSHIP PILOT

Senate bill 1045

The Housing Conservatorship Pilot
An Important New Tool

- San Francisco has several voluntary and involuntary programs.
- No existing program helps us reach the small group of people who have serious mental health and substance use disorder treatment needs and **do not consent to voluntary services.** Have increased risk of dying on our streets.
- Assisted Outpatient Treatment (AOT) requires history of inpatient hospitalization, violent behavior, or jail-based mental health treatment.
- LPS conservatorships do not account for the effects of psychoactive substances other than alcohol.
- As a result, these individuals are left behind.

What is Housing Conservatorship (SB1045)

- New conservatorship to help individuals who are unable to care for themselves due to a co-diagnosis of serious mental illness and substance use disorder.

- Individuals not currently served by existing models.

". . . Provide the least restrictive and most clinically appropriate alternative needed for the protection of a person who is incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder . . . "

Section 5453 of SB1045

Housing Conservatorship Eligibility Criteria

1. Inability to care for one's health and well-being.
2. Diagnosis of Serious Mental Illness.
3. Diagnosis of Substance Use Disorder.
4. Frequent 5150 detentions (at least 8 over 12 months).
5. The Court determines that and individual does not meet AOT criteria or AOT is insufficient to meet their needs.

POPULATION

Senate bill 1045

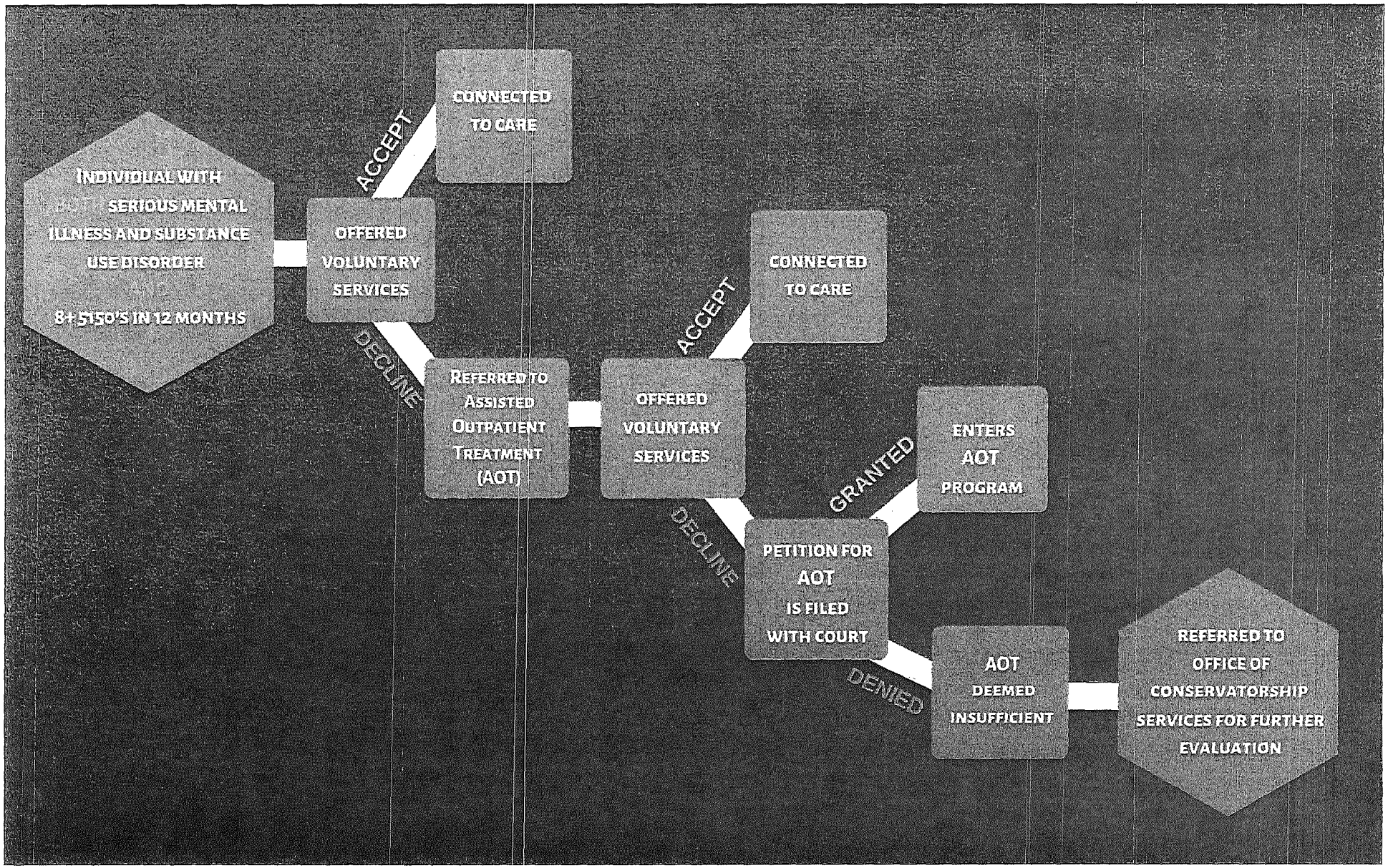
Eligible Population

- 55 individuals are currently eligible.
- Diagnosis of Serious Mental Illness and Substance Use Disorder.
- Individuals with 8+ involuntary holds (5150's) who received treatment.
- Average of 16.5 visits to PES/yr.
- 96.4% have an emergency department visit.
- 98.2% of the population had a history of experiencing homelessness (average of 8.9 years).
- 90.9% also have serious medical needs.
- 74.5% have been previously connected to a mental health provider.
- 34.5% have accepted an Acute Diversion Unit placement (average stay of 2.5 days)

PROCESS

Senate bill 1045

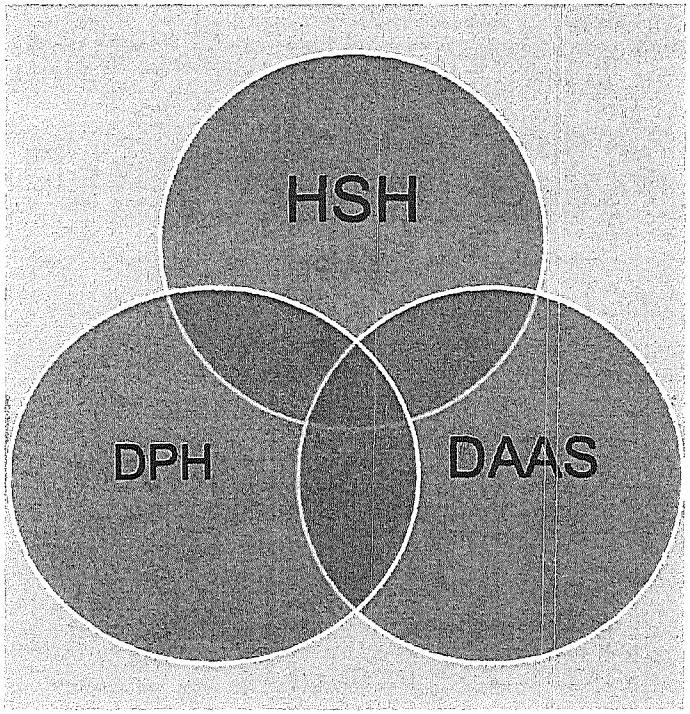
Housing Conservatorship Process



CONNECTION TO HOUSING

Senate bill 1045

Connection to Housing



- Court petition must include placement.
- Individuals are currently a top priority for housing options given our coordinated entry system.
- Any individual who has gone through the conservatorship will be guaranteed clinically appropriate housing placements along the way.
- Individuals who are ready for Permanent Supportive Housing will have guaranteed placement.

KEY PROVISIONS

Senate bill 1045

Key Provisions

- Established authority for San Francisco, San Diego and Los Angeles to pilot.
- Before implementation, the local legislative body in each county must legislatively opt in.
- Current legislation sunsets at the end of 2023.
- Local Working Group must be formed to provide Oversight once County opts in.

Judicial Process

- All clients have been offered voluntary services prior to petitioning the court for SB1045.
- All clients have access to legal representation from the Public Defender's office.
- Conservatorships last a maximum of one year. They may be shorter, or they can be renewed after one year by court order.
- Client may request a jury trial and/or re-hearing at any time to appeal conservatorship determination.

SB40 – Pending Legislation

- Duration of the conservatorship shortened to 6 months.
- Public Conservator to submit status report to the court every six weeks to justify continued need for conservatorship.
- Individual notified after the 7th involuntary hold of a possible, future conservatorship petition.
- Clarifies intent of AOT amendment made in SB1045.

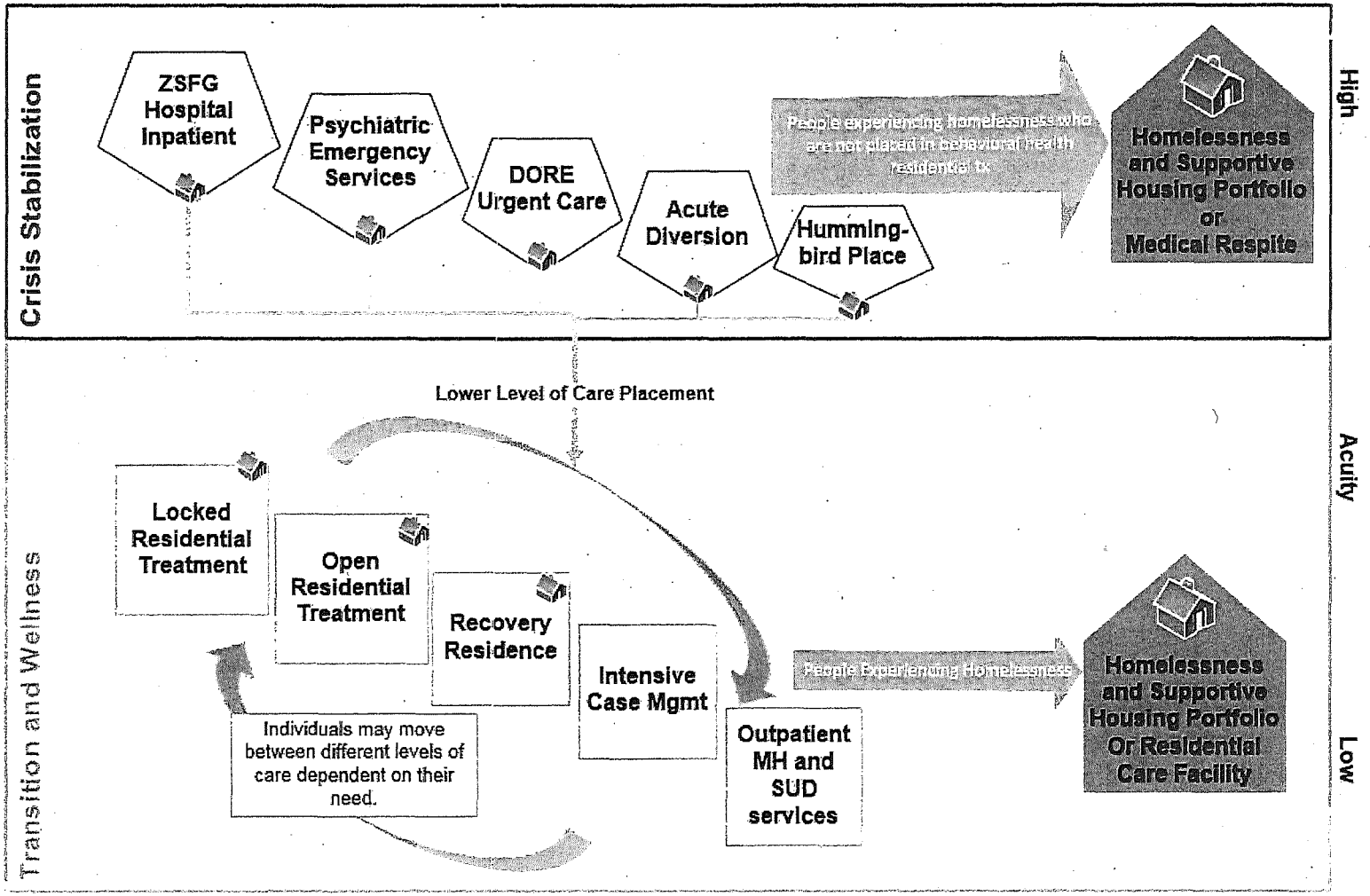
SERVICES AND IMPLEMENTATION

Senate bill 1045

Housing Conservatorship Services

- For some, AOT is not sufficient or they do not qualify. Housing Conservatorship is a next and final option.
- Client will receive wraparound, comprehensive services similar to those that are provided in AOT.
- Services will be focused on moving clients towards recovery and wellness.
- The bill prioritizes placement in community settings, or if appropriate, the Office of the Public Conservator can recommend higher levels of care.
- Legal obligation to continuously evaluate clients for transition downward into less restrictive settings.

SFDPH Behavioral Health Services



*This is not an exhaustive list of BHS beds and services

Slide 32

NL3 Do we need this slide? Isn't slide 38 sufficient?
Nicole Lindler, 5/10/2019

Clients Served: FY 2017-18

Mental Health (MH) Clients Served	
Provider	*Unduplicated Client Count*
Contract Providers	13,558
Civil Service Providers (including ZSFGH)	11,795
TOTAL UNDUPLICATED CLIENTS	21,907

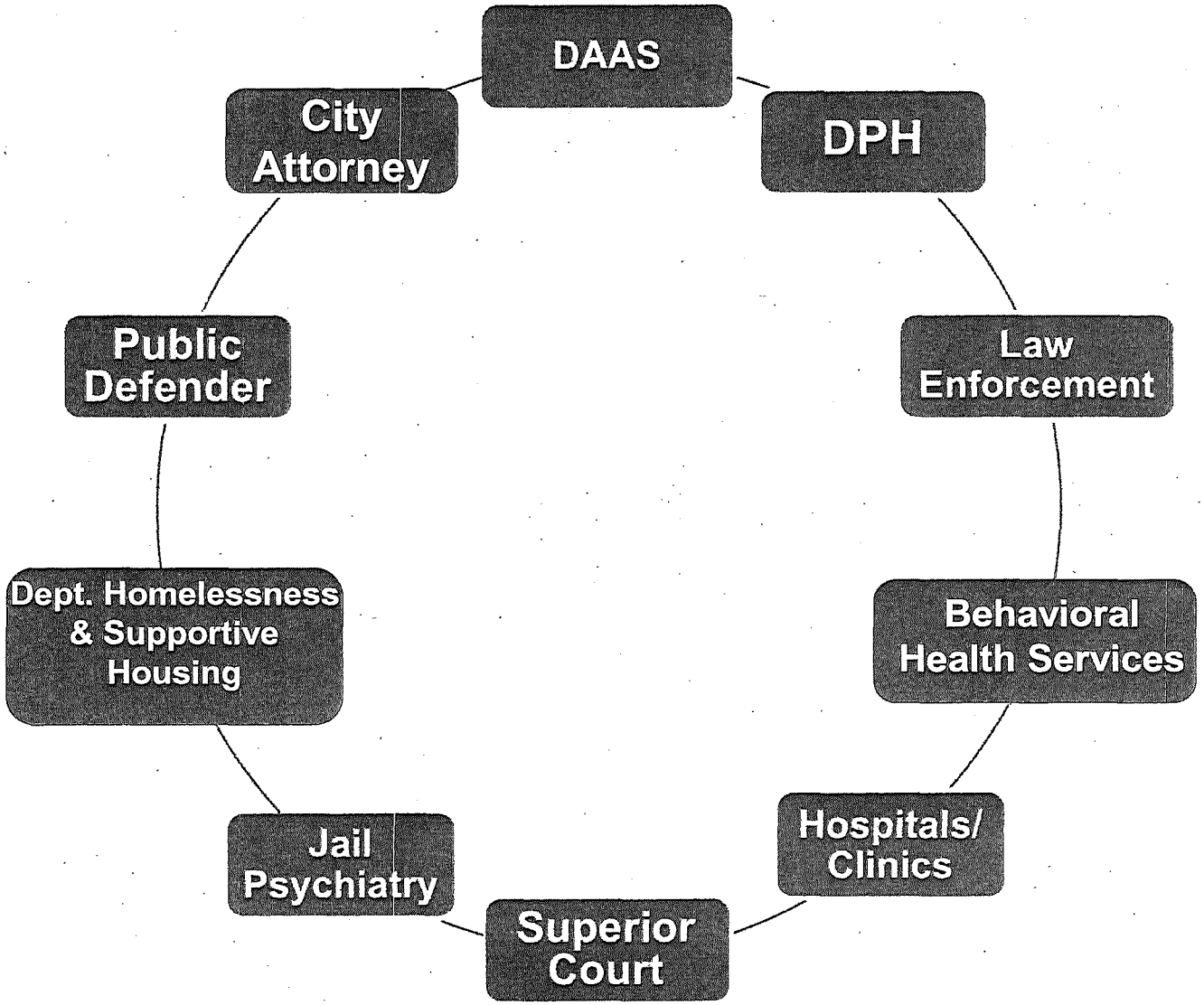
Substance Use (SU) Clients Served	
Provider	*Unduplicated Client Count*
Contract Providers	6,596
Civil Service Providers (including ZSFGH)	NA

Clients Receiving Both MH *and* SU Services: 2,214

Clients Served by Psychiatric Emergency Services (PES): FY 2017-18

- Crisis Stabilization Unit @ Zuckerberg San Francisco General Hospital.
  - Provides immediate evaluation and treatment
- County designated facility for individuals placed on a 5150 involuntary hold for up to 72hrs.
- FY 2017-18
  - 3,674 unduplicated individuals had visits to PES

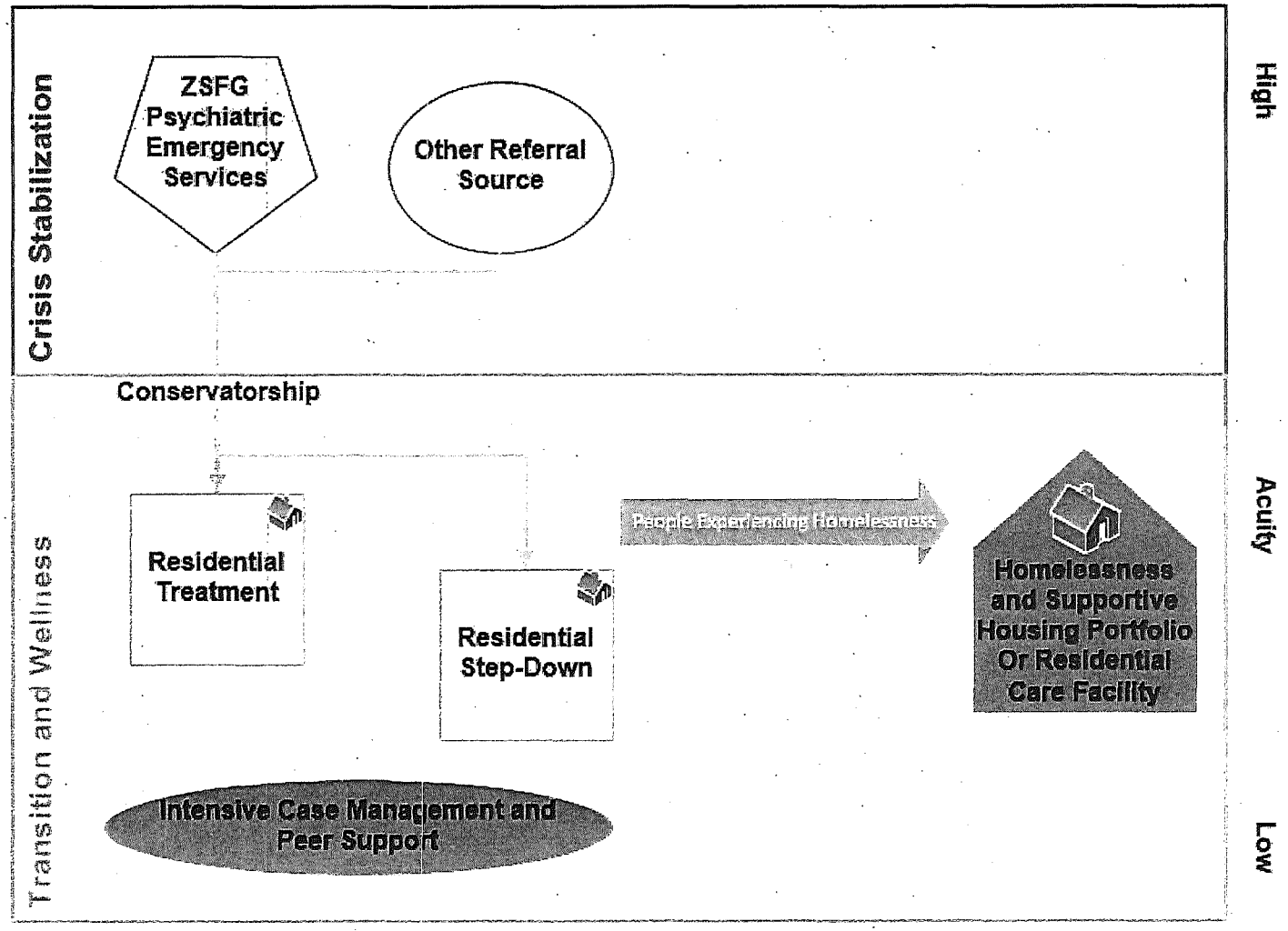
Conservatorship Services are Provided in Strong Partnership



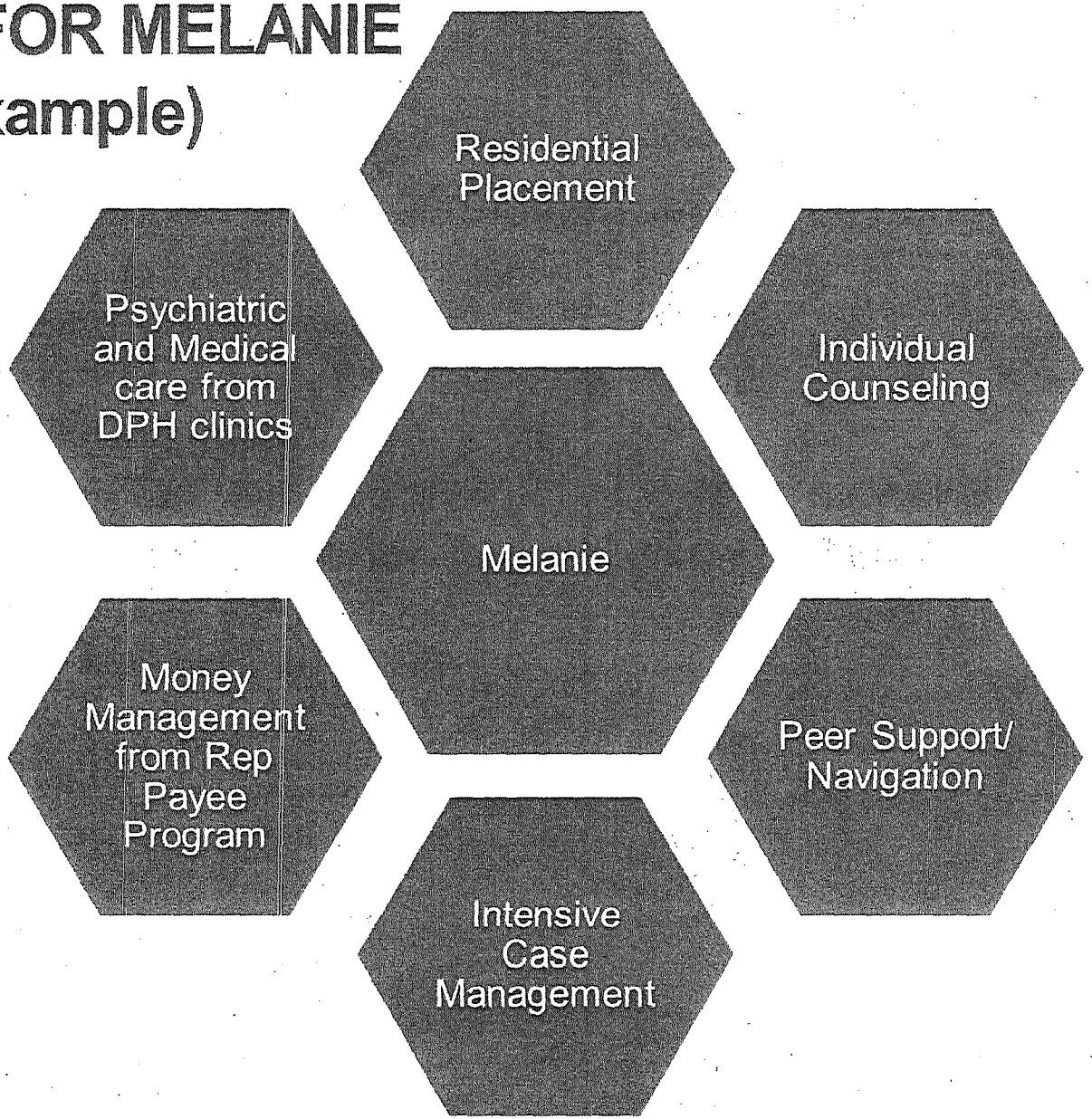
Tailored City Services to Meet Individual Needs

- Medical and psychiatric care
- Substance Use Disorder services
- Intensive outreach and case management
- Advocacy and individual service plans
- Money management
- Placement/Housing in the least restrictive setting
- Supportive counseling and peer engagement
- Vocational rehabilitation

Potential Conservatorship Pathway



A PLAN FOR MELANIE (example)



Recent Investments - Examples

- San Francisco Healing Center beds ($4.4m) –14 new beds (54 total).
- Substance use recovery beds ($5.0m) –72 new beds (178 total).
- $1 million to further stabilize residential care facilities.
- 30 new residential treatment beds.
- Hummingbird Place –14 new beds (29 total).
- And over 500 new units of permanent supportive housing by 2020; and 1600 new units by 2024.

Recent Investments - Examples

- $6m to support increased street based buprenorphine and street medicine team (10 people).

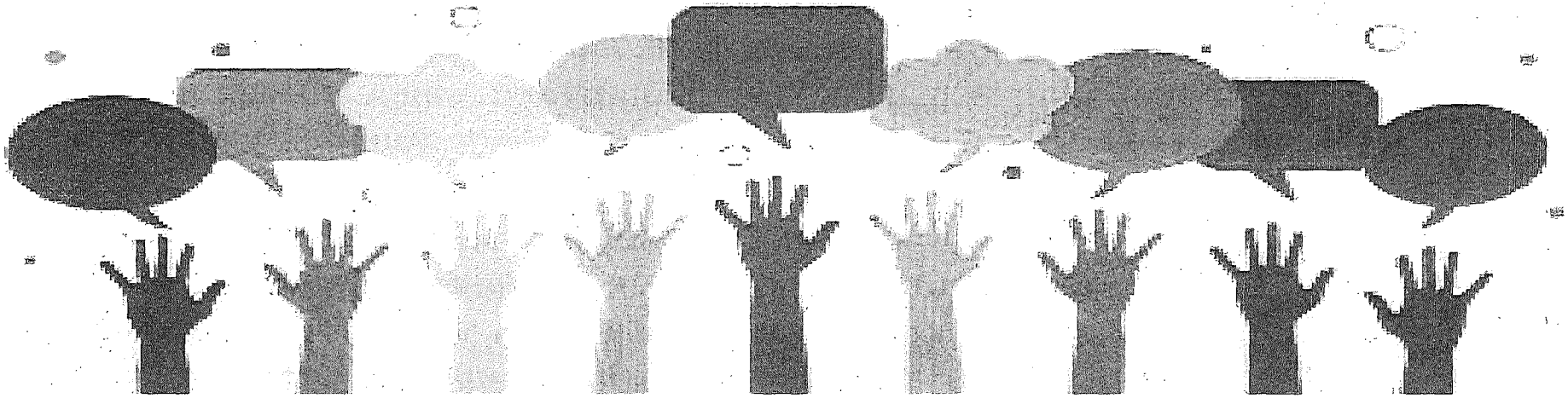
- 4 new clinicians to support AOT expansion and increased intensive case management.

- $3.2m to support:
  - Increased intensive case management
  - Extended Hours for drop in center @ Harm Reduction Center
  - Mobile harm reduction counseling
  - Peer navigators to support transition out of crisis services
  - Social workers at PES to support discharge planning

TESTIMONIAL

Simon Pang – Fire Dept

Questions?



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Editors' Choice

The effectiveness of compulsory drug treatment: A systematic review

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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.

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

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0955-3959/

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; Gowing, 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.

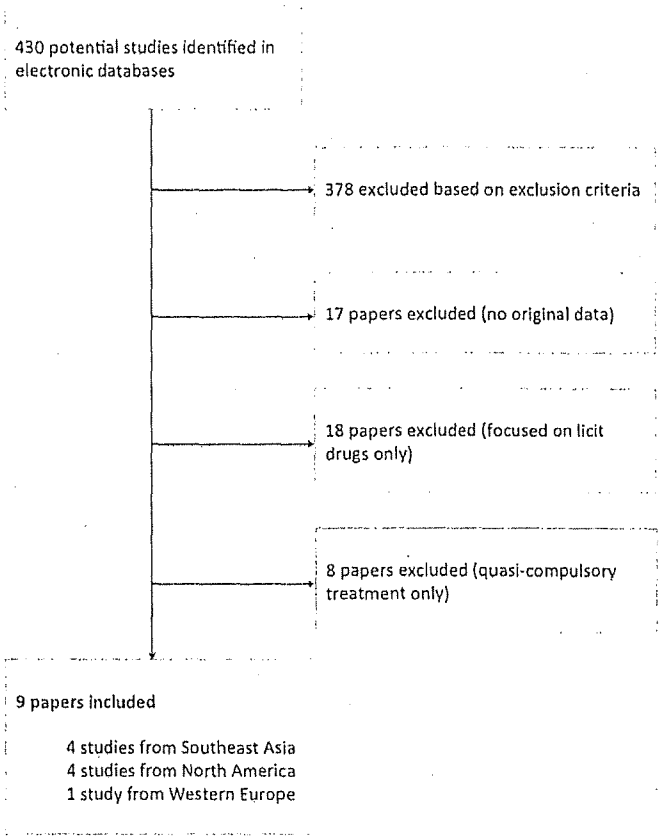

Fig. 1. Screening and study selection process.

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 (n_Y= 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 (n_Y= 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 (n_Y= 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 (n_Y= 290; participants who successfully completed six months of the TC treatment process), a dropout group (n_Y= 116; participants who failed to complete six months within the TC), and a comparison group (n_Y= 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; $p_Y > 0.05$). The proportion of participants incarcerated within 2 years did not differ significantly between the graduate and comparison groups (21% vs. 23%, $p_Y > 0.05$), though the dropout group had a significantly higher proportion of participants incarcerated compared with the other two groups (30%, $p_Y < 0.05$) (Hiller et al., 2006).

Jansson et al. (2008) investigated the long-term impact of compulsory residential care among drug-using individuals in Sweden (n_Y= 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 (n_Y= 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, $p_Y > 0.05$). 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 (n_Y= 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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Cochrane Database of Systematic Reviews

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**

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 mearntal 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, 2018 9:07 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.

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.

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,

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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

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

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

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

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)

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)

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

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

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

Young, Victor (BOS)

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.

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.

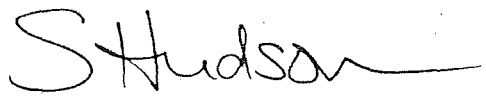
Furthermore, there is mounting evidence that compulsory treatment, especially without adequate follow-on care, is ineffective and can actually exacerbate the patient's condition. The UN has issued joint statement calling for the closing of compulsory treatment centers for drug "rehabilitation" and expansion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

Young, Victor (BOS)

From: Hans Kolbe <hanskolbe@celantrasystems.com>
Sent: Wednesday, May 08, 2019 8:41 PM
To: Young, Victor (BOS)
Cc: Carolyn Kenady; Mundy, Erin (BOS); rafaelmandelman@yahoo.com
Subject: support for SB1045 File No 181042

Dear Mr. Young

My family and I strongly support measure SB 1045 and its important conservatorship regulations. I also speak for the steering committee of the "Dolores Park Ambassadors", a neighborhood group with a subscriber list of more than 300 neighbors around Dolores Park and the surrounding areas. Too often we are confronted with mentally challenged persons who do not seem to be able to take care of or control themselves in our city environment. We are cooperating with police, park rangers, and city services in brining compassion and care towards these individuals. However, a small number of them need additional care and containment. The proposed legislation contains sufficient controls against abuse and provides much needed help to severely challenged individuals.

Best regards

Hans Kolbe
Celantra Systems
Cell US 415-730-1131

Young, Victor (BOS)

From: Hans Kolbe <hanskolbe@celantrasystems.com>
Sent: Wednesday, May 08, 2019 8:41 PM
To: Young, Victor (BOS)
Cc: Carolyn Kenady; Mundy, Erin (BOS); rafaelmandelman@yahoo.com
Subject: support for SB1045 File No 181042

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Best regards

Hans Kolbe
Celantra Systems
Cell US 415-730-1131

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place
Room 244
San Francisco, CA 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 544-5227

MEMORANDUM

Date: January 18, 2019

To: The Honorable Members, Board of Supervisors

From: Angela Calvillo, Clerk of the Board

Subject: Health, Administrative Codes - Housing Conservatorships (File No. 181042)

Board of Supervisors Rules of Order 2.21 establishes certain criteria that must be included in legislation creating and establishing, or reauthorizing, new bodies (boards/commissions/task forces/advisory bodies) and requires the Clerk of the Board to advise the Board on certain matters. In order to fulfill these requirements, the following information is provided.

File No. 181042 Health, Administrative Codes – Housing Conservatorship

The Ordinance would establish the Housing Conservatorship Working Group (HSWG).

- Does a current body address the same or similar subject matter?

  No, there is no active body with similar powers or duties. The HSWG shall conduct an evaluation of the effectiveness of the implementation of the California Welfare and Institutions Code (Chapter 5) in addressing the needs of persons with serious mental illness and substance use disorder in the City.

- Language requiring the body to meet at least once every four months

  The Ordinance does not address or set a minimum meeting requirement. I do suggest that the Ordinance be amended on Page 8, Line 16, to insert "and shall meet at least once every four months thereafter".

- Language indicating members serve at the pleasure of the appointing authority

  Page 8, Line 10, Section 5.37.3(a), entitled "Organization and Terms of Office," states "Members of the Working Group shall serve at the pleasure of their respective appointing authorities, and may be removed by the appointing authority at any time".

- Language establishing attendance requirements

  Page 8, Line 205, Section 5.37-3 (e), entitled "Organization and Terms of Office," states "Any member who misses three regular meetings of the Working Group within any 12-month period without the express approval of the Working Group at or before each missed meeting shall be deemed to have resigned from the Working Group 10 days after the third unapproved absence."

- Number of seats and qualifications

  Page 7, Line 1, Section 5.37-2, entitled "Membership," states "The Working Group shall be comprised of 12 members, appointed as follows:

  (a) Seats 1 and 2 shall be held by representatives of disability rights advocacy groups, appointed by the Mayor and the Board of Supervisors, respectively.
  (b) Seats 3 and 4 shall be held by representatives of labor unions, appointed by the Mayor and the Board of Supervisors, respectively.
  (c) Seats 5 and 6 shall be held by representatives of organizations providing direct services to homeless individuals or families, appointed by the Mayor and the Board of Supervisors, respectively.
  (d) Seat 7 shall be held by an employee of a hospital located in San Francisco with experience in mental health and substance use disorders, appointed by the Director of Health.
  (e) Seat 8 shall be held by an employee of the Behavioral Health Services program of the Department of Public Health, appointed by the Director of Health.
  (f) Seat 9 shall be held by an employee of the Department of Public Health, appointed by the Director of Health.
  (g) Seat 10 shall be held by an employee of the Human Services Agency, appointed by the Director of the Human Services Agency.
  (h) Seat 11 shall be held by an employee of the Department of Homelessness and Supportive Housing, appointed by the Director of the Department of Homelessness and Supportive Housing.
  (i) Seat 12 shall be held by an employee of the San Francisco Police Department, appointed by the Chief of Police.

- Term limits (i.e., commencement date? staggered terms?)

  Page 8, Line 10, Section 5.37-3, entitled "Organization and Terms of Office," does not reference a term limit. Therefore terms will be considered to be indefinite.

- Administering department

  The Department of Public Health shall provide administrative and clerical support to the HSWG.

- Reporting requirements

  The HCWG shall prepare and submit a preliminary report and a final report to the Mayor, the Board of Supervisors, and the Legislature on its findings and recommendations regarding the implementation of Chapter 5 (commencing with Section 5450) of the California Welfare and Institutions Code ("Chapter 5") in addressing the needs of persons with serious mental illness and substance use disorders in the City. The preliminary report shall be submitted to the Mayor and the Board of Supervisors by no later than November 1, 2020, and to the Legislature by no later than January 1, 2021, in compliance with Section 9795 of the California Government Code. The final report shall be submitted to the Mayor and the Board of Supervisors by no later than November 1, 2022, and to the Legislature by no later than January 1, 2023, in compliance with Section 9795 of the California Government Code.

- Sunset date

  The HCWG shall sunset on December 31, 2023, unless the Board of Supervisors extends the expiration date by Ordinance.

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

MEMORANDUM

TO: Shireen McSpadden, Executive Director, Department of Aging and Adult Services

FROM: Alisa Somera, Legislative Deputy Director
Rules Committee

DATE: November 15, 2018

SUBJECT: LEGISLATION INTRODUCED

The Board of Supervisors' Rules Committee has received the following proposed legislation, introduced by Mayor Breed on October 30, 2018:

File No. 181042

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

If you have comments or reports to be included with the file, please forward them to me at the Board of Supervisors, City Hall, Room 244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102 or by email at: alisa.somera@sfgov.org.

c: Bridget Badasow, Department of Aging and Adult Services

BOARD of SUPERVISORS

City Hall
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco 94102-4689
Tel. No. 554-5184
Fax No. 554-5163
TDD/TTY No. 554-5227

MEMORANDUM

TO: Greg Wagner, Acting Director, Department of Public Health
Helynna Brooke, Mental Health Board
Trent Rhorer, Executive Director, Human Services Agency
Jeff Kositsky, Director, Department of Homelessness and Supportive Housing
Vicki Hennessy, Sheriff, Sheriff's Department

FROM: Alisa Somera, Legislative Deputy Director
Rules Committee

DATE: November 13, 2018

SUBJECT: LEGISLATION INTRODUCED

The Board of Supervisors' Rules Committee has received the following proposed legislation, introduced by Mayor Breed on October 30, 2018:

File No. 181042

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

If you have comments or reports to be included with the file, please forward them to me at the Board of Supervisors, City Hall, Room 244, 1 Dr. Carlton B. Goodlett Place, San Francisco, CA 94102 or by email at: alisa.somera@sfgov.org.

c: Naveena Bobba, Department of Public Health
Sneha Patil, Department of Public Health
Krista Ballard, Human Services Agency
Emily Cohen, Department of Homelessness and Supportive Housing
Theodore Toet, Sheriff's Department
Katherine Gorwood, Sheriff's Department
Nancy Crowley, Sheriff's Department

OFFICE OF THE MAYOR
SAN FRANCISCO

LONDON N. BREED
MAYOR

TO: Angela Calvillo, Clerk of the Board of Supervisors
FROM: Kanishka Karunaratne Cheng
RE: Health, Administrative Codes - Housing Conservatorships
DATE: 10/30/2018

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

Please note that Supervisor Mandelman is a co-sponsor of this legislation.

Should you have any questions, please contact Kanishka Karunaratne Cheng at 415-554-6696.

1 DR. CARLTON B. GOODLETT PLACE, ROOM 200
SAN FRANCISCO, CALIFORNIA 94102-4681
TELEPHONE: (415) 554-6141

Lew, Lisa (BOS)

From:	Lew, Lisa (BOS)
Sent:	Thursday, November 15, 2018 4:08 PM
To:	McSpadden, Shireen (HSA)
Cc:	Rhorer, Trent (HSA); Badasow, Bridget (HSA); Somera, Alisa (BOS)
Subject:	BOS Referral: File No. 181042 - Health, Administrative Codes - Housing Conservatorships
Attachments:	181042 FYI DAAS.pdf

Hello,

The following proposed legislation is being referred to your department for informational purposes:

File No. 181042

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

Sent on behalf of Alisa Somera, Rules Committee. Please forward any comments or reports to Alisa Somera.

Regards,

Lisa Lew
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
P 415-554-7718 | F 415-554-5163
lisa.lew@sfgov.org | www.sfbos.org


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Lew, Lisa (BOS)

From:	Lew, Lisa (BOS)
Sent:	Tuesday, November 13, 2018 11:20 AM
To:	Wagner, Greg (DPH); 'hbrooke@mhbsf.org'; Rhorer, Trent (HSA); Kositsky, Jeff (HOM); Hennessy, Vicki (SHF)
Cc:	Bobba, Naveena (DPH); Patil, Sneha (DPH); Ballard, Krista (HSA); Cohen, Emily (HOM); Toet, Theodore (SHF); Gorwood, Kathy; Crowley, Nancy (SHF); Somera, Alisa (BOS)
Subject:	BOS Referral: File No. 181042 - Health, Administrative Codes - Housing Conservatorships
Attachments:	181042 FYI.pdf

Hello,

The following proposed legislation is being referred to your department for informational purposes:

File No. 181042

Ordinance amending the Health Code to authorize procedures for the appointment of a conservator for a person incapable of caring for the person's own health and well-being due to a serious mental illness and substance use disorder, and designating the City Attorney to institute judicial proceedings to establish housing conservatorships; and amending the Administrative Code to establish the Housing Conservatorship Working Group to conduct an evaluation of the City's implementation of the housing conservatorship program.

Sent on behalf of Alisa Somera, Rules Committee. Please forward any comments or reports to Alisa Somera.

Regards,

Lisa Lew
Board of Supervisors
San Francisco City Hall, Room 244
San Francisco, CA 94102
P 415-554-7718 | F 415-554-5163
lisa.lew@sfgov.org | www.sfbos.org


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From:	Hans Kolbe
To:	Young, Victor (BOS)
Cc:	Carolyn Kenady; Mundy, Erin (BOS); rafaelmandelman@yahoo.com
Subject:	support for SB1045 File No 181042
Date:	Wednesday, May 08, 2019 8:40:59 PM

Dear Mr. Young

My family and I strongly support measure SB 1045 and its important conservatorship regulations. I also speak for the steering committee of the "Dolores Park Ambassadors", a neighborhood group with a subscriber list of more than 300 neighbors around Dolores Park and the surrounding areas. Too often we are confronted with mentally challenged persons who do not seem to be able to take care of or control themselves in our city environment. We are cooperating with police, park rangers, and city services in brining compassion and care towards these individuals. However, a small number of them need additional care and containment. The proposed legislation contains sufficient controls against abuse and provides much needed help to severely challenged individuals.

Best regards

Hans Kolbe
Celantra Systems
Cell US 415-730-1131