May 11, 2022

The Honorable Anthony Portantino
Chair, Senate Appropriations Committee
1021 O Street, Ste. 6730
Sacramento, CA 95814

RE: SB 1338 (Umberg) - OPPOSE

Dear Senator Portantino:

The organizations sending this letter advance and protect the civil rights of Californians living with disabilities, experiencing homelessness, and involved in the criminal legal system. Respectfully, we **oppose SB 1338**.

The CARE Court framework that SB 1338 seeks to establish is unacceptable for a number of reasons, **including major fiscal concerns, which can be found on page 12.**

- It does not guarantee housing as a solution to address homelessness;
- Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment;
- It will perpetuate institutional racism and worsen health disparities;
- There are flaws in SB 1338's reliance on a person's lack of capacity to make medical decisions;
- Use of the terms "Supportive Decision-Making" and "Supporter" reflects a misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court; and
- Critical terms and concepts are not defined by SB 1338 or elsewhere in California law.

We believe that a transformational proposal like CARE Court should be thoroughly vetted by stakeholders and informed by research and data before it is adopted. That has not happened here. Because CARE Court will harm Californians with disabilities, experiencing homelessness, and involved in the criminal legal system, we cannot support this proposal.

I. Background

The California Legislature has declared that, "[i]n the absence of a controversy, a court is normally not the proper forum in which to make health care decisions."[1] Yet, SB 1338 seeks to establish a new court system in which health care decisions will be made. Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court is a system of coerced, court-ordered treatment that strips people with mental health disabilities of their right to make their own decisions about their lives.

CARE Court is antithetical to recovery principles, which are based on self-determination and self-direction.[2] The CARE Court proposal is based on

[1] Probate Code § 4650(c). "Return to Main Document"

[2] Substance Abuse and Mental Health Services Administration, *SAMHSA's Working Definition of Recovery* (https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf). "Return to Main Document"

stigma and stereotypes of people living with mental health disabilities and experiencing homelessness.

While the organizations submitting this letter agree that State resources must be urgently allocated towards addressing homelessness, incarceration, hospitalization, conservatorship, and premature death of Californians living with severe mental illness, CARE Court is the wrong framework. The right framework allows people with disabilities to retain autonomy over their own lives by providing them with meaningful and reliable access to affordable, accessible, integrated housing combined with voluntary services.

II. Ending homelessness for all Californians living with mental health disabilities requires guaranteed housing provided with fidelity to principles that prioritize voluntary services.

Instead of allocating vast sums of money towards establishing an unproven system of court-ordered treatment that does not guarantee housing, the state should expend its resources on a proven solution to homelessness for people living with mental health disabilities: guaranteed housing with voluntary services. Given that housing is proven to reduce utilization of emergency services and contacts with the criminal legal system, a team of UC Irvine researchers concluded that it is "fiscally irresponsible, as well as inhumane" not to provide permanent housing for Californians experiencing homelessness.[3]

To effectuate guaranteed housing, California should use the funds targeted towards CARE Court to instead make large-scale investments in low-barrier, deeply affordable (15% of area median income or less), accessible, integrated housing for people experiencing homelessness. This housing should be made available with access to voluntary, trauma-informed, culturally-responsive, evidence-based services such as Assertive Community Treatment, Intensive Case Management, Peer Support, and substance use disorder services that follow the Harm Reduction approach.

Informed by Housing First Principles, California has recognized that it is crucial to use housing as a tool rather than a reward for recovery, and to provide or connect unhoused people to permanent housing as quickly as

[3] David A. Snow and Rachel E. Goldberg, *Homelessness in Orange County: The Costs to Our Community* (June 2017) at 43 (https://www.unitedwayoc.org/wp-content/uploads/2017/08/united-way-cost-study-homelessness-2017-report.pdf). "Return to Main Document"

possible. Housing First principles, as an evidence-based model, require offering services as needed and requested on a voluntary basis, and not making housing contingent on participation in services.[4] By statute, state programs that provide housing or housing-based services to people experiencing homelessness or at risk of homelessness must adopt guidelines and regulations to incorporate the core components of Housing First.[5]

Evidence shows that housing provided with fidelity to Housing First principles leads to the types of positive outcomes for unhoused people that the state is misguidedly proposing to attain via CARE Court. For example, a recent UCSF randomized controlled study of unhoused high utilizers of public systems in Santa Clara County found that permanent supportive housing (which incorporates Housing First principles) combined with intensive case management, significantly reduced psychiatric emergency room visits and increased the rate of scheduled outpatient mental health visits compared to the control group.[6] In addition, Housing First programs that closely adhere to the evidence-based model result in positive housing and substance use outcomes for chronically homeless people with substance use disorders.[7]

CARE Court flies in the face of any evidence-based approach to ending homelessness. It requires a person to be court-ordered into a treatment plan that includes a "housing plan," without any guarantee that the plan will ever lead to permanent housing. As the Health and Human Services Agency recognizes, "finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle."[8] On this premise, a person should be offered housing

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[4] Welf. & Inst. Code § 8255(d)(1). "Return to Main Document"

[5] Welf. & Inst. Code § 8256(a). SB 1338's stated plan to give CARE Court participants priority for the "Behavioral Health Bridge Housing" proposed in the Governor's Budget violates the State's commitment to Housing First as codified here. CARE Court is *not* a Housing First program because it will likely require participants to comply with a program or services as a condition of tenancy. "Return to Main Document"

[6] Maria C. Raven, M.D., M.P.H., M.Sc., *et al*., *A Randomized Trial of Permanent Supportive Housing for Chronically Homeless Persons with High Use of Publicly Funded Services*, Health Services Research 2020;55 (Suppl. 2): 797 at 803. "Return to Main Document"

[7] Clare Davidson, M.S.W., *et al*., *Association of Housing First Implementation and Key Outcomes Among Homeless Persons with Problematic Substance Use*, Psychiatric Services 2014; 65:1318 at 1323. "Return to Main Document"

[8] California Health and Human Services Agency, *CARE Court: A New Framework for Community Assistance, Recovery, and Empowerment* (https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf) (accessed April 10, 2022). "Return to Main Document"

before they can be reasonably expected to engage in mental health services. Because SB 1338 specifically precludes a court from ordering housing and does not require a county to provide housing, CARE Court will create a system of distrust and further hinder participants from obtaining appropriate treatment and services by employing a coercive model. With SB 1338's built-in presumption that "failure to comply" will lead to a "factual presumption that no suitable community alternatives are available" to treat the person, CARE Court is a fast track to conservatorship and re-institutionalization of people with mental health disabilities, exactly the outcomes that SB 1338 purports to avoid.

III. Evidence shows that adequately-resourced intensive voluntary outpatient treatment is more effective than court-ordered treatment.

Despite SB 1338's use of the terms "recovery" and "empowerment," CARE Court sets up a system of coerced, involuntary outpatient civil commitment that deprives people with mental health disabilities of the right to make self-determined decisions about their own lives. Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment provided in accordance with evidence-based practices.[9] Conversely, evidence shows that involuntary, coercive treatment is harmful.[10]

In 2000, the California Senate Committee on Rules commissioned the RAND Institute to develop a report on involuntary outpatient treatment, with a primary objective to identify and synthesize empirical evidence on the effectiveness of involuntary outpatient treatment and its alternatives.[11] The findings of the RAND report remain relevant today. Then and now, no studies exist to prove that a court order for outpatient treatment *in and of*

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[9] Joseph P. Morrissey, Ph.D., *et al*., *Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*, Psychiatric Services 2014:812 at 814 (2014). "Return to Main Document"

[10] S.P. Sashidharan, Ph.D., *et al.*, *Reducing Coercion in Mental Healthcare*, Epidemiology and Psychiatric Sciences 2019: 28, 605-612 (All forms of coercive practices are inconsistent with human rights-based mental healthcare); Daniel Werb, Ph.D., *et al.*, *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, International Journal of Drug Policy 2016: 28, 1-9 (Because evidence, on the whole, does not suggest improved outcomes related to compulsory drug treatment approaches and some studies suggest potential harms, non-compulsory treatment modalities should be prioritized by policymakers seeking to reduce drug-related harms). "Return to Main Document"

[11] M. Susan Ridgely, *et al.*, *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*, RAND Health and RAND Institute for Civil Justice, 2001 (https://www.rand.org/pubs/monograph_reports/MR1340.html). "Return to Main Document'

itself has any independent effect on client outcomes.[12] Studies show that any positive effects that result from outpatient commitment are due to the provision of intensive services, and whether court orders have any effect at all in the absence of intensive treatment is an unanswered question.[13] In addition, a well-resourced treatment system with the appropriate infrastructure to deliver high-intensity services is critical for the success of any outpatient commitment program.[14]

On the other hand, the RAND study provided strong evidence of the effectiveness of Assertive Community Treatment (ACT), a multidisciplinary, community-based intervention that combines the delivery of clinical treatment with intensive case management.[15] The report's authors concluded that there is clear evidence that, when implemented with fidelity to evidence-based models, community-based mental health interventions like ACT can produce good outcomes for people living with severe mental illness.[16] Furthermore, psychosocial rehabilitation programs are evidence-based recovery models and interventions considered best practices in addressing the recovery of unhoused individuals with mental health disabilities.[17] The State's resources would be better utilized to expand and strengthen the availability of ACT, psychosocial rehabilitation recovery models, and other intensive evidence-based treatment modalities throughout California.[18]

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[12] *Id*. at xvi. "Return to Main Document"

[13] *Id*. at 27. "Return to Main Document"

[14] *Id*. at 67. "Return to Main Document"

[15] *Id*. at 29. The primary difference between California's Full Service Partnerships (FSP) and ACT is that there is no evidence-based model that FSPs must follow. There is significant variation in FSP delivery across counties. Some counties have ACT programs as part of their FSP offerings. When offered as part of an FSP, ACT generally provides a more engaged level of service than the standard FSP. "Return to Main Document"

[16] *Id*. at 32. "Return to Main Document"

[17] Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System that Works for All People Living with SMI and SED and their Families and Caregivers* (December 13, 2017) at 25 (https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf). "Return to Main Document"

[18] The recent behavioral health needs assessment published by DHCS found that ACT is not yet available with fidelity on the scale necessary to support optimal care for people who could benefit from the level of engagement that it offers. State of California, Department of Health Care Services, *Assessing the Continuum of Care for Behavioral Health Services in California: Data, Stakeholder Perspectives, and Implications* (January 10, 2022) at 60 (https://www.dhcs.ca.gov/Documents/Assessing-the-Continuum-of-Care-for-BH-Services-in-California.pdf) "Return to Main Document"

IV. CARE Court will perpetuate institutional racism and worsen health disparities.

Due to a long and ongoing history of racial discrimination in housing, banking, employment, policing, land use and healthcare, Black people experience homelessness at a vastly disproportionate level compared to the overall population of the state. In Los Angeles County alone, Black people make up 8% of the population, but 34% of people experiencing homelessness.[19] Statewide statistics are even more dire: 6.5% of Californians identify as Black or African-American, but they account for nearly 40% of the state's unhoused population.[20]

In addition, research shows that Black, indigenous, and people of color (BIPOC) and immigrant racial minorities are more likely to be diagnosed with psychotic disorders than white Americans.[21] In California, rates of serious mental illness vary considerably by racial and ethnic groups, with. American Indian and Alaska Native and Black Californians experiencing the highest rates of serious mental illness.[22]

By targeting unhoused people with diagnoses of schizophrenia and other psychotic disorders, CARE Court will exacerbate health disparities under the directive of a court system. CARE Court will disproportionately impact BIPOC Californians, who are significantly more likely to be homeless and diagnosed with such conditions.

V. There are numerous flaws in SB 1338's reliance on a person's lack of capacity to make medical decisions as a condition of eligibility for CARE Court.

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[19] Steve Lopez, *Column: Black people make up 8% of L.A. population and 34% of its homeless. That's unacceptable.*, Los Angeles Times, June 13, 2020 (https://www.latimes.com/california/story/2020-06-13/column-african-americans-make-up-8-of-l-a-population-and-34-of-homeless-count-heres-why). "Return to Main Document"

[20] Kate Cimini, *Black people disproportionately homeless in California*, Cal Matters, October 5, 2019 (updated February 27, 2021) (https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/). "Return to Main Document"

[21] Robert C. Schwartz, Ph.D., *et al*., *Racial disparities in psychotic disorder diagnosis: A review of empirical literature*, World Journal of Psychiatry 2014: 4:4, 133-140. "Return to Main Document"

[22] California Health Care Foundation, *Health Disparities by Race and Ethnicity in California: Pattern of Inequity* (October 2021) at 33 (https://www.chcf.org/wp-content/uploads/2021/10/DisparitiesAlmanacRaceEthnicity2021.pdf). "Return to Main Document"

The CARE Court framework described by SB 1338 rests on the premise that certain people diagnosed with schizophrenia or other psychotic disorders may be court-ordered into treatment if they lack medical decision-making capacity. This premise has serious flaws. SB 1338 ignores California's legal requirements that must be met before a finding that a person lacks medical decision-making capacity is legally authorized. In addition, requiring a finding that a person lacks medical decision-making capacity as a prerequisite for ordering a person into CARE Court services undermines the entire CARE Court framework, which assumes a participant's ability to participate in the development of their treatment plan and ultimately consent to it without the appointment of a substitute decision-maker.

A. SB 1338 ignores specific procedures that California requires to determine whether a person lacks capacity to make medical decisions.

Californians are presumed competent to make health care decisions.[23] The law is clear that "the mere diagnosis of a mental or physical disorder shall not be sufficient in and of itself to support a determination that a person is of unsound mind or lacks the capacity to do a certain act" and that a finding of incapacity to make a certain decision or do a certain act must be based on evidence of a deficit in a mental function related to the decision or action in question.[24] Because the right to refuse medical treatment is a fundamental liberty interest regarding one's bodily autonomy, the right to due process attaches when it is questioned.

California law is very clear about the process, which includes the right to a court hearing, that must be followed to determine whether a person lacks medical decision-making capacity.[25] SB 1338 does not require any of these steps. Instead, it allows unacceptable shortcuts: submission of an affidavit of a behavioral health professional based on an evaluation that occurred up to three months prior or not at all, or evidence of an LPS hold within the past 90 days. Neither of these shortcuts is sufficient to prove that a person lacks capacity to make medical decisions or satisfy due process requirements for stripping a person of their right to control their bodily autonomy and make their own medical decisions.

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[23] Probate Code § 4657. "Return to Main Document"

[24] Probate Code § 811(a), (d). "Return to Main Document"

[25] Probate Code §§ 3200-3212. "Return to Main Document"

B. Finding that a person lacks capacity to make medical decisions requires offering a treatment plan on a voluntary basis first, with the opportunity to give informed consent.

Under California law, "capacity" means "a person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks, and alternatives."[26]

According to this definition of capacity, a person must be provided with a description of the proposed treatment plan, information about risks, benefits, and alternatives to the plan, and an opportunity to voluntarily engage in the plan *before a finding of incapacity is made*. Under the language of SB 1338, the process is reversed: a person is first found incompetent to make decisions about medical treatment and, only after such finding, offered any information about the proposed treatment. This reversed approach does not pass muster under California laws governing incompetency to make medical decisions.

C. Requiring a lack of capacity as a necessary element of ordering a person to CARE Court effectively eviscerates the proposed legislation.

The premise of CARE Court is that a person can "choose" to enter a court-ordered treatment plan that they have participated in developing. However, this is failed logic if a prerequisite for an order to CARE Court is that a person lacks capacity to make medical decisions. Requiring a lack of capacity as a necessary element of ordering a person to CARE Court completely undermines the framework, inasmuch as SB 1338 presumes that individuals are capable of actively participating in the development of their treatment plans, specifically requires that they be afforded the opportunity to do so, and does not contemplate the appointment of a substitute decisionmaker to consent to the plan.[27]

VI. Use of the terms "Supported Decision-Making" and "Supporter" in the context of a coercive court-ordered treatment scheme reflects a serious misunderstanding of the concepts behind the terms and obscures the involuntary nature of CARE Court.

[26] Probate Code § 4609. "Return to Main Document"

[27] See Matter of K.L., 1 N.Y.3d 362, 369 (2004). "Return to Main Document"

SB 1338's use of the terms "Supported Decision-Making" and "Supporter" to describe certain court-ordered components of the CARE Court process is so inconsistent with well-established definitions of those concepts that the usage is not just inaccurate. It is misleading and problematic.

Supported Decision Making (SDM) is a practice that has been recognized and endorsed by the Administration for Community Living of the U.S. Department of Health and Human Services, (which funds the National Resource Center for Supported Decision-Making),[28] the American Bar Association Commission on Law and Aging,[29] and the United Nations Convention on Rights of Persons with Disabilities.[30] Across the board, these entities have used the term SDM to refer to a model or practice that enables individuals to make choices about their own lives with support *from a team of people they choose*. With SDM, individuals *choose people they know and trust* to be part of a support network that helps them understand their issues, options, and choices. The role of the supporter is to offer guidance and advice, but to ultimately honor and help carry out the choices made by that individual, regardless of whether the supporter thinks they are in the person's best interest.[31]

Contrary to SB 1338's statement of findings and declarations, the new "CARE Supporter" role will not advance and protect self-determination and civil liberties of Californians living with severe mental illness. More troublingly, the "CARE Supporter" role is not just acting within a coercive system but also has the potential to be an agent of that system. If a person "fails" or does not comply with their "CARE plan," they risk being forced into a conservatorship based on reports from the "CARE Supporter" about whether the person followed their plan. Therefore, because these "CARE

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[28] American Bar Association, *Guardianship and Supported Decision-Making* (https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/). "Return to Main Document"

[29] National Center on Law & Elder Rights, *Legal Basics: Supported Decision-Making* (https://ncler.acl.gov/pdf/Legal-Basics-Supported-Decision-Making1.pdf). "Return to Main Document"

[30] United Nations Department of Economic and Social Affairs/Disability, *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities Chapter Six: From Provisions to Practice: Implementing the Convention – Legal Capacity and Supported Decision-Making* (https://www.un.org/development/desa/disabilities/resources/handbook-for-parliamentarians-on-the-convention-on-the-rights-of-persons-with-disabilities/chapter-six-from-provisions-to-practice-implementing-the-convention-5.html). "Return to Main Document"

[31] Center for Public Representation, *About Supported Decision Making* (https://supporteddecisions.org/about-supported-decision-making/) (accessed April 8, 2022). "Return to Main Document"

Supporters" are appointed for the express purpose of assisting with decisions as part of the CARE Court process, they are more accurately "court-appointed navigators," and should be recognized as such.

Because a person's choice of their own supporters is at the heart of SDM, it cannot exist within a framework of a coercive court-ordered treatment scheme where a judge appoints a navigator whom the individual has never met and has no reason to trust.

Disability Rights California and Disability Rights Education and Defense Fund—signatories to this letter—are co-sponsors of AB 1663 (Maienschein), the Probate Conservatorship Reform and Supported Decision-Making Act, which seeks to codify SDM as part of the Probate Code. AB 1663 passed out of this committee with a vote of 10-0. The bill makes clear that SDM allows a person with a disability to choose *voluntary supports* to help them with decisions, *as requested*. SB 1338's misappropriation of these concepts and proposed statutory language from AB 1663, without using the appropriate definitions of the terms, undermines the true meaning and value of SDM.

VII. Many critical terms and concepts are not defined by SB 1338 or anywhere else in California law.

SB 1338 does not adequately define critical terms and concepts necessary to provide adequate understanding of the parameters of CARE Court. This lack of clarity will result in confusion and inconsistent application of the law across the state. These terms and concepts include, but are not limited to:

- "Not clinically stabilized in on-going treatment with the county behavioral health agency" (§ 5972(c));
- "Qualified behavioral health professional" (§ 5975(g)(1));
- Criteria for "graduation" from CARE Court (§ 5977(h)(1));
- Criteria for "reappointment" to CARE Court (§ 5977(h)(1));
- Criteria and process for finding that a person is "not participating in CARE proceedings" or "failing to comply with the CARE plan" (§ 5979(a));
- Criteria and process for terminating a participant from CARE Court 5979(a));
- Criteria and process for finding that a county is not complying with court orders (§ 5979(b)); and

- Criteria and process for finding that a county is “persistently noncompliant” (§ 5979(b)).

VIII. Fiscal Considerations

For the purposes of the Appropriations Committee’s consideration, we believe CARE Court will be a costly mistake, diverting resources from people who need other care and investing resources in ways that will make CARE Court not just a failure but a costly one as well. CARE Court is time limited assistance with forced treatment, which has a history of more harm than good. A better use of these significant funds will be to invest in a robust housing framework for this target population and provide services.

The new court infrastructure is likely to fail at accomplishing Community Assistance, Recovery, and Empowerment (CARE). Still, an investment in courts is likely to cost in excess of hundreds of millions of dollars, if not more. Part of this may be one-time funding, but to the extent the court system needs to augment and train a workforce for the new responsibilities under CARE Court, we can estimate at least tens of millions of dollars in ongoing costs.

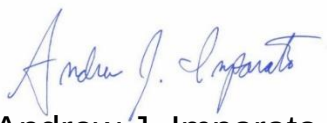
The bill is targeting 7,000 to 12,000 people with severe mental illness but it is unclear how they will be found, how they will get to court, and how much will be spent on care teams of providers through county behavioral health departments. Services would require extensive staffing. Ongoing costs could be at least in the hundreds of millions of dollars statewide. Current funding for mental health services, already insufficient to meet needs, will likely be diverted to pay for CARE Court, risking services for others, including children and youth. In addition, much of CARE Court will not be reimbursable through Medi-Cal.

Although there is a requirement for a care plan that includes a housing plan, the bill contains no authority for a court to order housing. Without housing first, there is a high likelihood of failure even if a robust menu of services is provided. If a person fails their care plan, “subsequent proceedings may use the CARE proceedings as a factual presumption that no suitable community alternatives are available to treat the individual.” Effective treatment takes time and anticipates relapse on the road to recovery. The high risk of failure, which may not be the fault of the individual, makes it likely the state will incur significant but indeterminate costs on conservatorships and state hospitals.

IX. Conclusion

CARE Court is not the appropriate tool for providing a path to wellness for Californians living with mental health disabilities who face homelessness, incarceration, hospitalization, conservatorship, and premature death. Instead, California should invest in evidence-based practices that are proven to work and that will actually empower people living with mental health disabilities on their paths to recovery and allow them to retain full autonomy over their lives without the intrusion of a court.

Sincerely,



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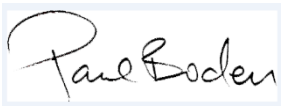

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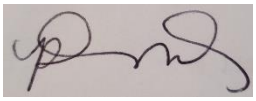

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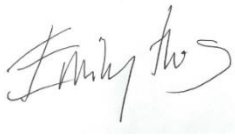

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The New York Times

Why Forced Addiction Treatment Fails

April 30, 2022

By Maia Szalavitz

Jason Norelli, a San Francisco native, spent several years homeless in and around the city's Tenderloin district, addicted to methamphetamine. In 2001, he was legally mandated to attend rehab and has been in recovery ever since. Today he helps others like him get care.

Mr. Norelli's experience makes him seem like a poster child for legally mandated addiction treatment. At least 37 states now have laws on the books that allow parents, police or concerned others to petition courts to compel rehab through civil commitment if a judge deems someone a threat to themselves or others.

Twenty-five such laws were passed or expanded between 2015 and 2018 alone, according to a recent investigation by The Intercept, and this growth continues. This month, Massachusetts proposed an increase in funding to its civil commitment program for addiction, bringing it to about $23 million. In March, Gov. Gavin Newsom of California proposed a new system of "CARE Courts," to expand civil commitment for homeless people with schizophrenia and often addiction.

But voluntary rehab has a better track record and is less likely to harm the people it is intended to help. Criminalization and coercion have helped create a patchwork of addiction programs that is harsh, low quality, underfunded, understaffed and too often fraudulent. Since legally mandated care is often the only way to get immediate and free treatment, a damaging cycle continues.

To do better, the United States needs more evidence-based treatment. And since the data shows that the best treatment is compassionate and inviting, coercion should be the last resort, not the first.

Mr. Norelli opposes compulsory drug treatment. He feels that being forced into treatment can push people in the other direction if they are not ready to quit. "Of the

hundred people that came in at the same time I did, only a few completed it," he said, adding that he is still disturbed by the "humiliating" way they were treated.

Despite having some inspiring counselors, the rehab he was required to attend used, among other methods, so-called attack therapy, an unscientific approach in which the therapist and other group members try to break individuals by shouting hurtful things at them to destroy a person's "addictive" personality.

Instead, Mr. Norelli believes it was positive forces in his life, like his family and the desire to spend time with his son, that kept him motivated, despite the dehumanizing tactics.

Supporters of compulsory drug treatment — which often include family members of people with addiction — frequently argue that it is the only way to get their loved ones to stop doing drugs, and so remain alive. And for decades, addiction experts argued that research supports legally mandated treatment. In 2018, the National Institute on Drug Abuse said that "treatment doesn't need to be voluntary to be effective," in its document on principles of quality care.

Now, however, the consensus has shifted. "The data does not show that it's beneficial to put someone in jail or prison or force them against their will to go to treatment," said Dr. Nora Volkow, the director of the N.I.D.A. She notes that people frequently use anecdotes (like Mr. Norelli's) to favor mandatory treatment. "There are absolutely instances where people may have had a positive outcome," she said. "But it's the minority."

A 2016 research review shows why. Of the nine studies included, five found no significant reductions in drug use or crime among people who underwent required treatment, and two studies found that mandated therapy made those measures worse. Only two studies found a small benefit in short-term recovery. This is in contrast with the strong literature on voluntary medication use for opioid addiction, which shows that it can reduce mortality by 50 percent or more.

Massachusetts has one of the most frequently used civil commitment systems for addiction, and the results are grim. Much of the treatment takes place in prisons, and lawsuits and reporting has described filthy conditions and lack of access to addiction medications proven to save lives. The state's statistics show that people who have been committed are twice as likely to die of opioid-related overdose as those who seek help voluntarily. A meta-analysis looking at studies in the United States and around the world of involuntary treatment and H.I.V. and overdose-related risk found similar results.

So why is forced rehab so politically popular? One answer is that it comes across as centrist, mixing law and order with therapy. Another is that families often aren't aware that there are more effective ways to motivate recovery.

Legal coercion undermines many aspects of effective addiction therapy. It can be difficult to trust providers whose job involves reporting on you to a court. Since relapse

is common and often leads to legal consequences, this can discourage disclosure. Coercion can also smother the internal desire to change, which is known to be critical for long-term success.

Fortunately, the same people who balk at commands will often voluntarily take action if persuaded that it will help them get what they want. One of the most successful addiction treatments, motivational enhancement therapy, focuses on helping people build relationship and career goals. Proponents of this approach say it allows people to see for themselves that their drug use is an obstacle, creating desire to change.

Another therapy, called Community Reinforcement and Family Therapy (CRAFT), teaches families to lovingly motivate people with addiction and is more effective than other treatments. A third highly effective approach, known as contingency management, uses rewards like free movie tickets instead of punishment. But these therapies are, unsurprisingly, rarely available in mandated treatment.

It's often argued that people with the most severe addictions won't accept help because they deny that they need it. The California CARE Court system, for example, will treat people with schizophrenia, including those who have addiction as well, who are seen as more likely to be resistant to receiving treatment.

But even here, coercion is rarely needed. Research finds that 86 percent of people with long histories of frequent emergency room visits and arrests who have diagnoses of substance use and severe mental illness will accept and persist in housing with supportive care. This includes being guided by advocates through the bureaucracy and welcomed without the rigid rules requiring perfect abstinence that are typical in rehabs and housing programs.

In other words, spending more on reducing barriers to care and housing, and improving the quality of treatment so that people with addiction actually want to participate will be far more effective than adding yet more money for courts and cops.

Moreover, reducing compulsory treatment will improve the quality. Currently, more than a quarter of people in rehab are legally mandated. Many more have little choice about the help they receive because of insurance rules, or lack of insurance.

But if fewer people were forced to simply accept what's offered, programs would have to become friendlier. It's basic capitalism: Customer service is better when businesses compete than when consumers have no choice.

Today Mr. Norelli is a manager at Glide Harm Reduction, part of a church in the heart of the Tenderloin, which, since the crack era, has explicitly tried to attract people into recovery with love, not shame. This includes offering meals, referrals to treatment and housing and clean needles — as well as joyous musical worship.

"Any chance I get to bring some love and compassion into that formula, I do it," he said. "And I see the results of that. People have better outcomes."