Insights from California on Involuntary Commitment for Substance Use

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Involuntary commitment (IC) for the treatment of substance use disorders is a highly controversial and poorly understood practice, with California offering a striking example. The state's involuntary commitment laws, known collectively as Lanterman-Petris-Short, authorized IC for grave disability related to chronic alcoholism. These provisions remain shrouded in obscurity, and data on their usage are lacking. Amid the ongoing debate over the utility of IC as a tool to treat severe substance use disorders and legislation expanding IC for substance use disorders (SUDs) in California and other states, this article highlights the need to better study the use and effectiveness of existing legislation as well as to consider upstream interventions, such as expansion of community-based treatment models.

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Alcohol use disorder (AUD) poses a significant societal burden. The nationwide lifetime prevalence of severe AUD is nearly 15 percent; the figure increases to 29.1 percent when all severity levels of AUD are considered.[1] Excessive alcohol use cost the United States $240 billion in 2010.[2] Hospital visits involving alcohol use cost $7.6 billion in 2017.[3] Excessive alcohol consumption is the fourth leading cause of preventable death in the United States,[4] and chronic use can lead to a vast array of diseases. Various neuropsychiatric symptoms and diagnoses have been associated with heavy alcohol use, such as depression,[5] suicide,[6] and dementia.[7] And although a variety of evidence-based psychosocial and medication treatments exist for AUD,[8] the disorder remains undertreated.[8–10]

Some cases of severe AUD may result in the individual being unable to manage their care safely in the community. One approach to managing these individuals is involuntary commitment (IC). IC is a contentious legal process that typically begins by forcibly detaining an individual to provide treatment in a medical or psychiatric facility. The legal criteria for IC are highly variable from state to state but are commonly based on the dangerousness standard, in which detainment is pursued because an individual is believed to be a danger to self or others.[11] A 2016 study found that 19 states permit IC for inability to care for oneself due to a mental disorder (commonly known as grave disability)[11] and 35 states also permit the use of IC for dangerousness or grave disability arising from substance use, such as alcohol.[12] Unfortunately, there is a lack of data[13] or studies[14] on the application or effectiveness of IC for substance use specifically. The state of California exemplifies this dilemma. Its hallmark IC legislation, known collectively as Lanterman-Petris-Short (LPS), allows for involuntary psychiatric detention to treat grave disability due to a mental disorder or chronic alcoholism.[15,16] Although data on the use or utility of the chronic alcoholism criterion are extremely limited, the state in 2023 passed legislation that would expand the definition of grave disability and allow it to apply to all severe substance use disorders, not simply chronic alcoholism.

This article describes what is known about the use of IC for alcohol use in California. First, we present the history of IC for substance use in California. Then, we describe recent legislative efforts to modernize LPS in the face of rising rates of substance use

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and homelessness, emphasizing the lack of data on IC both in California and in the United States generally. We argue that, despite mounting pressure for reform, every effort must be made to better characterize the use of the chronic alcoholism criterion before the state implements alterations to the scope of IC to address AUD and other substance use disorders. Without these data, California and states that may be looking to California for guidance on this topic could be left with legislation that is insufficiently evidence based.

Background

In the second half of the 20th century, the legal debate over the effectiveness of IC for substance use primarily hinged on differing opinions regarding the extent to which substance use was a compulsion. The debate was exemplified by two landmark cases from the 1960s: *Robinson v. California* (1962)[17] and *Powell v. Texas* (1968).[18] In *Robinson*, police officers observed track marks on the arm of Lawrence Robinson. Inferring a history of intravenous substance use, they arrested him on suspicion of being addicted to narcotics, which was a jailable offense in the state of California. He was convicted, but following a series of appeals, the U.S. Supreme Court ruled that the statute violated the Eighth Amendment's cruel and unusual punishment clause. The conviction was overturned. The majority opinion also posited that addiction could arise involuntarily, such as through exposure to drugs *in utero* or by prescription.[17]

The role of voluntariness in addiction arose again six years later in *Powell v. Texas*. Leroy Powell was arrested and convicted for public intoxication. He appealed his conviction on the grounds that chronic alcoholism was a disease that compelled him to drink. Echoing the majority ruling in *Robinson*, Mr. Powell argued that punishing someone for behavior stemming from a disease was cruel and unusual. His appeal reached the Supreme Court, which issued a plurality opinion against Mr. Powell emphasizing the ambiguity of the term chronic alcoholism. Although the Court opined that addiction might arise involuntarily in *Robinson*, it did not find that criminal behaviors associated with addiction were exculpatory in *Powell*.[18]

Powell highlighted a key flaw in the disease concept of chronic alcoholism. Namely that, as of 1968, the medical field had not arrived at a unified understanding of chronic alcoholism as a disease entity.[18] In the first[19] and second[20] editions of the *Diagnostic and Statistical Manual of Mental Disorders* (published in 1953 and 1968, respectively), alcoholism was a phenomenon attributed to other diagnoses, such as personality disorders, but lacked specific diagnostic criteria because it was not a diagnosis itself. Alcoholism was not recognized as an independent diagnosis until the publication of *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition (DSM-III) in 1980, 12 years after *Powell*.[21] DSM-III also abandoned the term alcoholism and created two separate diagnoses: alcohol dependence and alcohol abuse.[21] This classification was retained in *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV),[22] and it was not until *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) in 2013 that these diagnoses were combined into the parsimonious alcohol use disorder to integrate both physiologic and behavioral aspects of problematic substance use into a single set of diagnostic criteria.[23]

Another key outcome of *Powell* was that efforts to reform the criminalization of substance use would be left increasingly to legislatures and the executive branch as opposed to the courts.[24] Some of this reform was already underway prior to *Powell.* In 1965, President Lydon B. Johnson formed The President's Commission on Law Enforcement and Administration of Justice (also known as The Katzenbach Commission) to identify areas of criminal justice reform, including the criminalization of public drunkenness.[25] The necessity to shift the burden of substance use management away from the penal system was made clear by the report issued by The Katzenbach Commission in 1967, which declared that "the criminal justice system appears ineffective to deter drunkenness or to meet the problems of the chronic alcoholic" (Ref. 25, p. 67). In 1968, Maryland passed legislation that offered detoxification as well as inpatient and outpatient services for those detained for public drunkenness.[26] Washington, D.C. passed similar legislation as early as 1947,[27] but it was not consistently enforced until *Easter v. District of Columbia* (1966).[28] In 1967, California passed the Lanterman-Petris-Short Act (LPS), which defined criteria and durations allowed for involuntary care of people experiencing mental illness.[29] Two forms of detainment specified by the act (a 14-day hold and a temporary conservatorship lasting up to 30 days) could be applied related to grave disability attributed to chronic alcoholism.[15,16] The lengthiest form of commitment in LPS (conservatorship, sometimes referred to as

guardianship in jurisdictions outside of California) could last for up to one year under LPS before renewal was required.[16]

LPS has been cited as being widely influential on the creation of involuntary commitment laws in other states.[30] Unfortunately, data on the use of the chronic alcoholism criterion have been lacking since the earliest days of LPS, limiting evidenced-based judgments of its effectiveness. This follows a broader pattern seen across the United States, in which there are few data to be found on the use of IC for psychiatric or substance use conditions.[14,31] This has not stopped California, like other states, from revising its IC laws in efforts to better address persistently high rates of substance use, homelessness, and other challenges that intensified after the drafting of landmark IC legislation in the 1960s.[32] We hope to show that the history and current use of IC for chronic alcoholism in California may contain lessons that are applicable to states grappling with the complex problem of IC and substance use in a data-poor environment.

California as a Case Study

Early IC reform efforts in California were ambivalent on the question of criminalized substance use. On the one hand, between 1967 and 1968, over 200,000 arrests were made in California for public intoxication. These typically resulted in brief periods of detention in the "drunk tank,"[25] and recidivism rates were high. It was estimated that, in 1965, one-third of public intoxication offenders accounted for two-thirds of those arrested for that crime.[25] In 1969, Los Angeles County spent over $9 million per year ($71 million in 2023 inflation-adjusted dollars) to incarcerate people who were arrested for public drunkenness.[25]

On the other hand, by permitting IC and psychiatric care for chronic alcoholism, LPS implicitly acknowledged that a certain subset of individuals struggling with problematic alcohol use were better served in a hospital than a jail. In fact, the preparatory reports for LPS noted that 27 percent of state hospital commitments in 1965 were for alcoholism and anticipated that "aged senile persons or physically debilitated alcoholics" would be the majority of people found gravely disabled and conserved under the reformed law (Ref. 33, p 138). In apparent recognition of the compulsion to drink underlying addiction, the state legislature also made various efforts at diverting those arrested for public intoxication to involuntary treatment (so-called inebriate reception centers), although these were never signed into law.[24,25] Moreover, original LPS legislation contained only procedural guidance on the topic of IC for substance use. Although it did provide additional funding to ensure that the legislation could be operationalized, this funding was rapidly cut.[34]

The result was a set of laws that sought to criminalize one potential and common outcome of chronic alcoholism (public intoxication) while allowing for psychiatric care by way of IC for another outcome (inability to care for oneself). Data on early outcomes of these laws are scarce. A law review article published in 1978 shed light on the use of conservatorship generally, stating that, between 1972 and 1973, a total of 36,133 people were placed on a 72-hour hold; of these, some 3,296 were ultimately placed on lengthy conservatorships.[35] The author does not describe how many conservatorships were placed on the basis of chronic alcoholism. A study from 1992 that followed 60 patients who had been conserved for grave disability under LPS concluded that conservatorship could play an important role in the longitudinal management of their psychiatric illness. None of these conservatorships were noted to have been issued for grave disability due to chronic alcoholism.[36]

The extent to which IC is used for people experiencing chronic alcoholism remains largely unknown, complicating legislative initiatives for reform or allocation of appropriate resources for treating AUD. A recent audit of LPS published by the California state auditor in July of 2020 makes evident the obscurity and apparent lack of use of IC for chronic alcoholism in the state.[37] The report concluded that LPS was largely functioning as intended, whereas county-level utilization of outpatient resources, such as assisted outpatient treatment and intensive case management (which were meant to ease the transition from involuntary commitment to living in the community) was lacking.[37] Meanwhile, the matter of chronic alcohol use and substance use in general was largely unaddressed in the LPS audit. In fact, the sole mention of the chronic alcoholism criterion occurred in a footnote that explained, "Because the cases we reviewed almost exclusively identified individuals' mental illnesses as the reasons they met the LPS Act criteria, we focus our report on those aspects of the LPS Act" (Ref. 37, p. 10). A similar observation was made in 2022, when the San Francisco Board of Supervisors Policy Analysis Report issued a review of

the use of LPS Conservatorship in San Francisco County through 2019.[38] The report noted that the "Public Conservator staff did not know of studies indicating the prevalence of alcoholism among individuals referred to LPS conservatorship" (Ref. 38, p. 7). In fact, the only documented case of an attempt to conserve someone for chronic alcoholism took place in San Francisco; the conservatorship was dropped when no suitable facility could be found.[39]

Despite an incomplete understanding of how commitment laws are used in cases of chronic alcoholism, there have been various efforts at LPS reform as it relates to substance use. Among the most significant of these came in 2018 with the implementation of California Welfare & Institutions Code (WIC) § 5450,[40] which acknowledges the co-morbid intersection of homelessness, substance use disorder, and primary psychiatric pathology.[41,42] Creating the possibility of pilots in San Francisco, Los Angeles, and San Diego counties, WIC § 5450 authorizes a 12-month conservatorship for an individual with serious mental illness and substance use disorder when that person has undergone at least eight three-day holds in one year, among other criteria.[40] During that period, the conservator is responsible for both treatment and housing decisions.[40] Preliminary data on the statute's use indicated that, since its enactment in 2019, only one county participated and just three individuals were conserved.[43] These results call into question the effectiveness of a purely legislative approach to substance use disorder conservatorship without appropriate funding or institutional will to engage with new statutes.[44]

The use of the term substance use disorder in WIC § 5450, as opposed to the much narrower chronic alcoholism found in WIC § 5250[15] and WIC § 5350,[16] points to an unfortunate reality: the types and prevalence of problematic substance use, including AUD, have changed dramatically since the drafting of LPS over 50 years ago. Although rates of problematic alcohol use were difficult to quantify because of inconsistent definitions of alcoholism prior to the publication of DSM-III,[45] one-year prevalence of alcohol dependence and abuse was estimated to be 4.4 percent in the *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised (DSM-III-R).[46] This figure increased to 7.4 percent in DSM-IV.[22] The DSM-5 estimates the one-year prevalence of AUD to be 8.5 percent.[23] In a 2018 study, six percent of Californians met criteria for AUD, compared with three percent for all illicit substance use disorders.[47] The same study found that, between 2012 and 2014, alcohol accounted for more emergency department visits than all other substance use disorders combined.[47]

California, like other states, has also witnessed the rise of other use disorders. For instance, opiate-related emergency department visits increased by 300 percent between 2006 and 2017, and the number of amphetamine-related emergency department visits increased by 50 percent between 2018 and 2020.[48] In recognition of the changing landscape of substance use, state officials have called into question whether existing legislation is sufficient to meet the needs of those who are chronically incapacitated because of substance use other than alcohol. Consider San Francisco County's reply to the 2020 audit of LPS, in which they emphasized the role of "psychoactive substances outside of chronic alcohol use" as a factor that disrupts clinicians' ability to enact the legislative intent of LPS (Ref. 37, p 106).

Attempts to modify mental health law to address changes in substance use trends are best exemplified by two recent and controversial California Senate Bills. Senate Bill 326, signed into law in October 2023, asked voters to approve a change to the 2004 Mental Health Services Act (MHSA) to include treatment of those with substance use disorders (SUDs).[48] The law is slated to provide $6.4 billion to build treatment beds and housing for those experiencing severe mental illness, substance use disorders, or both.[49] Critics point out that Senate Bill 326 may require significant county-level budget carveouts, which would lead to decreased funding of critical outpatient and crisis mental health programs, resources that could be made even scarcer by the inclusion by those seeking treatment for a SUD under MHSA.[50]

California Senate Bill 43, introduced in December of 2022, seeks to modify LPS itself.[51] The bill, which was signed into law on October 10, 2023, changes the definition of gravely disabled to include those with a severe SUD (replacing the phrase chronic alcoholism) or a co-occurring psychiatric disorder and a severe SUD.[51] Senate Bill 43 also expands the definition of grave disability itself to include a failure to manage one's personal safety or necessary medical care.[51] Critics of the bill have pointed out that its broadening of IC criteria could excessively facilitate institutionalization.[52] Moreover, all but two counties

have evoked a provision in Senate Bill 43 allowing them to delay implementation until 2026. Most have cited concerns that there are insufficient placements for people detained under new SUD provisions, which they anticipate will increase 10-fold.[53] It appears that Senate Bill 43 could follow a well-documented tradition[54,55] of California mental health legislation in which laws that would expand IC for SUDs (such as chronic alcoholism in the original LPS act) are insufficiently funded.

Civil Commitment for SUDs

Despite urgent calls for involuntary commitment reform, there are limited available data on the use of civil commitment statutes generally[31,56] and for substance use disorders, such as AUD, specifically. In California, WIC § 5402 mandates that the state issue public reports quarterly on the number of individuals who have been placed on LPS holds, including those holds that may be placed for grave disability due to chronic alcoholism.[57] These data do not specify those situations in which grave disability was deemed to be due to chronic alcoholism. Encouragingly, the state does appear to be aware of this deficit. SB 43 (the same legislation aiming to loosen IC criteria) will expand data collection under WIC § 5402 to include the frequency of involuntary commitment placement for grave disability due to severe SUD or severe SUD and mental illness.[51]

Some studies suggest that physicians may generally be in favor of involuntary commitment to address SUD. A 2021 survey of addiction medicine providers found that 60 percent of respondents were in favor of involuntary commitment for SUDs.[58] In this study, 165 members of the American Society of Addiction Medicine were surveyed on their opinions regarding IC for SUDs. A majority (60.7%) were in favor, whereas just 21.5 percent opposed. Interestingly, 74.7 percent of respondents favored IC specifically for alcohol (second only to heroin, for which IC was favored by 79% of respondents).[59] Further, 28.8 percent of respondents were unsure whether their state authorized IC for SUDs, underlining the need for better physician education in this domain. In a separate 2021 survey study of 175 Massachusetts court clinicians, 73.3 percent disagreed that civil commitment for SUD does more harm than good and 53.3 percent would like more training.[60] Meanwhile, a 2018 review of commitment laws for SUD concluded that there are insufficient data to determine whether involuntary commitment for SUDs can improve clinical outcomes.[32]

The question of whether IC for substance use constitutes a strategy worth pursuing is complex and outside the scope of this article, which seeks only to underline the importance of data collection. Historically the debate has turned on the question of whether substance use disorders are a disease and the extent to which substance use is believed to be voluntary.[61,62] Opinions on this debate appear to shift cyclically,[44] and there is currently a national push to loosen or broaden commitment criteria.[63–66] In the case of California, this is illustrated by legislation that is seeking to broaden commitment criteria, such as SB 43. And this is to say nothing of a spate of recent op-eds that are highly critical of a perceived lack of community and inpatient mental health resources. These are often penned by families of loved ones who, in their view, are not receiving the mental health and substance use care they need, even if that need includes involuntary care.[67–74] The end result is that state legislatures, facing pressure from concerning SUD rates and negative media framings of IC laws that appear neglectful, are left to revise pivotal legislation without the relevant data at hand.

In the absence of statute-relevant data, state legislatures may approach the problem of commitment reform from a philosophical, legislative, or political stance, which may fail to consider data on how current legislation is, or is not, used. There are several reasons to believe that other states may look to California for guidance on this topic. First, California's problems are not unique: the scourge of homelessness and substance use in California is a nationwide phenomenon but has drawn particular attention in coastal states with Democratic leadership, like New York or Oregon.[75] Second, since the inception of LPS, California's involuntary commitment laws have served as a model for other states. By incorporating IC for SUD into the same statute as IC for mental illness, California is diverging from the more common approach of states like Florida, which have separate statutes and distinctive commitment criteria for each.[76] California's newer approach is worth watching carefully, because combining statutes may help better address comorbidities but may also mean that IC procedures are not adapted to the specificities of SUD, which are addressed in other states through criteria that emphasize impaired decision-making capacity.

Future Directions

Lessons from California show that implementing these provisions is often complicated and hard to achieve without additional resources, data collection, and acceptance from community services. As a first step, states that authorize civil commitment for SUDs should conduct more thorough data collection on how relevant statutes are currently used before expanding involuntary care further. In the case of California, SB 43's approach involved IC statutes being broadened before data on their use were examined in greater detail. Ideally, this investigation would occur before IC legislation related to SUD is significantly revised.

Additional less restrictive interventions may be able to help individuals avoid IC for SUDs as well. In the case of AUD, at least some of these interventions are underutilized.[8] Despite there being multiple evidence-based treatments, including medications and various forms of psychotherapy, it has been reported that only 14.6 percent of those individuals with an AUD received any treatment.[8] The underutilization of SUD treatment may be the result of denial of the need for treatment among some people with SUD. A 2019 survey estimated that a mere one percent of 40 million individuals with an illicit drug or alcohol use disorder in the past year agreed with the need for treatment and attempted to seek it.[77] Increased access to secondary prevention measures, such as cognitive behavior therapy and medications that reduce alcohol cravings, may prevent the progression of mild or moderate-to-severe AUD, thereby reducing the need for IC in the first place.

One outpatient-driven approach to SUD is already underway. In 2022, California's state legislature passed the Community Assistance, Recovery, and Empowerment (CARE) Act, a form of court-ordered treatment that lasts up to two years and is designed to treat those experiencing serious mental illness as well as substance use disorders. The intervention is expressly designed to avoid downstream interventions, such as LPS conservatorship, in cases of severe SUD and mental illness. Select counties, including Los Angeles, San Diego, and San Francisco, began implanting the act between October and December 2023.[78] Finally, SB 326 is seeking to expand the Mental Health Services Act to include the treatment of SUDs, which would provide up to $36 million for staffing required to fund additional substance use treatment services.

Further, additional research is needed to examine and address the social determinants of health that place an individual at risk of requiring involuntary commitment, including conservatorship. For example, people experiencing homelessness (PEH) are at increased risk of developing SUDs[79] and experiencing more severe consequences of SUD,[80] have greater utilization of emergency medical services, are at greater risk of developing psychiatric illnesses,[80] and require long-term care at greater rates compared with non-PEH peers also experiencing SUD.[80] Encouragingly, a 2021 observational study found that, among PEH, improving access to housing and SUD treatment may reverse many of the relationships described above.[81] In California, SB 326 attempts to address this problem by funding housing for those experiencing severe mental illness and SUDs. This may occur at the expense of outpatient SUD services that would otherwise provide secondary prevention to reduce the chance that a SUD becomes severe enough to result in homelessness.

Other less-restrictive approaches include assertive community treatment (ACT) and assisted outpatient treatment (AOT). ACT provides intensive, community-based care for patients who have severe mental illness but might also be adapted to support the needs of people with substance use disorders. ACT for mental illness has been the subject of more than 25 randomized control trials (RCTs), and several studies indicate ACT is associated with decreased hospitalization rates. These studies often had mixed findings, and suboptimal funding of ACT may hamper the use of these services as intended.[82] A 2019 systematic review of ACT for patients with SUDs yielded mixed results but suggested that ACT may be helpful in reducing substance use in those patients with high levels of inpatient service utilization.[83] In assisted outpatient treatment (AOT), patients are mandated to receive services while remaining in the community.[84] Data on compulsory treatment of SUDs are limited,[83] and the ability of AOT to prevent rehospitalization in three separate RCTs is mixed.[84] More research is needed to understand the effectiveness of the AOT model for people experiencing SUDs.

Conclusion

Amid national calls to expand involuntary care for people with SUDs, there is an urgent need to better understand the use and effectiveness of existing legislation that authorizes these interventions. California

offers a striking example, as its involuntary commitment statutes for grave disability due to chronic alcoholism remain obscure to many and appear to be hardly used across the state. Increased data collection on the use of commitment laws for SUDs, such as IC for alcoholism in California, could better inform evidence-based policymaking. Identifying less-restrictive interventions, such as increasing access to primary and secondary prevention services as well as addressing social determinants of health, may also be helpful for preventing people with AUD and other SUDs from deteriorating to the point of becoming unable to care for themselves and for avoiding the need for IC in the first place.

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