Grading the States: An Analysis of Involuntary Psychiatric Treatment Laws
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Executive Summary

The U.S. mental health system is not one single broken system, but many. Responsibility for making needed reform is in the hands of the states and thousands of local governments. Each has a unique set of laws, regulations, policies and budget priorities that, collectively, make up our national mental health system.

We are effectively running 50 different experiments, with no two states taking the same approach. As a result, whether a person receives timely, appropriate treatment for an acute psychiatric crisis or chronic psychiatric disease is almost entirely dependent on what state that person is in when the crisis arises.

Grading the States: An Analysis of U.S. Psychiatric Treatment Laws examines the laws that provide for involuntary treatment for psychiatric illness. For each state, we analyzed whether an individual who needs involuntary evaluation or treatment can receive it in a timely fashion, for sufficient duration, and in a manner that enables and promotes long-term wellbeing.

We found that on some issues, states are close to universal use of recommended best practices that we identify in our policy recommendations.

- A robust majority of states authorize an emergency psychiatric hold of at least 72 hours for evaluation and crisis care
- Only a small number of states require that danger to self or danger to others be imminent to qualify for hospitalization
- Nearly all states recognize a person’s failure to meet basic needs (such as food, clothing and shelter) due to mental illness as a basis for intervention
- All but three states have laws that authorize civil commitment on an outpatient basis

But we also identified many states whose criteria have not been updated for many years, whose laws create needless barriers to treatment for people with severe mental illness, and whose procedures are confusing or vague, making them even more difficult to navigate for families and practitioners alike.

Our purpose in writing this report is not to shame states whose laws need to improve, but it is absolutely critical that people understand the connection between flawed civil commitment laws and the bad outcomes that they see in their communities every day. Emergency holds that are too short lead to “streeting,” the abominable practice of discharge without care because a person has simply “timed out” of their opportunity for intervention. Impossibly high civil commitment criteria prevent a person in crisis from accessing excellent outpatient programming. As discussed in the 2017 report Beyond Beds: The Vital Role of a Full Continuum of Care, no law exists in a vacuum. A loved one can fall through the cracks if any one part of the treatment continuum fails. For many, this can mean violence, arrest, trauma or victimization.

The majority of states receive neither top nor bottom grades, with most earning a B or C.
Figure 1: Distribution of State Grades

<table>
<thead>
<tr>
<th>Grade</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>Minnesota (97)</td>
</tr>
<tr>
<td>A</td>
<td>Wisconsin (96), Michigan (95), West Virginia (94)</td>
</tr>
<tr>
<td>A</td>
<td>North Dakota (92), Vermont (92), Arkansas (91), Hawaii (91), Louisiana (90), Wyoming (90)</td>
</tr>
<tr>
<td>B+</td>
<td>Indiana (89), South Carolina (88), Mississippi (87), Washington (87)</td>
</tr>
<tr>
<td>B</td>
<td>Missouri (86), Ohio (86), Idaho (85), Nevada (84), Oregon (84), Arizona (83)</td>
</tr>
<tr>
<td>B</td>
<td>Georgia (82), Illinois (82), Virginia (82), Iowa (80), North Carolina (80)</td>
</tr>
<tr>
<td>C+</td>
<td>Kentucky (79), Oklahoma (79), Pennsylvania (79), Maine (77), Texas (77)</td>
</tr>
<tr>
<td>C</td>
<td>New York (76), New Mexico (75), Kansas (73), Utah (73)</td>
</tr>
<tr>
<td>C</td>
<td>South Dakota (72), Colorado (71), New Hampshire (71)</td>
</tr>
<tr>
<td>D+</td>
<td>New Jersey (67)</td>
</tr>
<tr>
<td>D</td>
<td>Florida (66), Alaska (65), Nebraska (63)</td>
</tr>
<tr>
<td>D</td>
<td>Alabama (60), California (60)</td>
</tr>
<tr>
<td>F</td>
<td>Montana (59), Tennessee (57), Rhode Island (57), District of Columbia (56), Connecticut (41), Massachusetts (33), Delaware (30), Maryland (18)</td>
</tr>
</tbody>
</table>
Our analysis found the following:

- Ten states earned an A grade, while eight received an F.
- Minnesota achieved the highest combined score, with 97 out of 100 points. Maryland received the lowest combined score, with 18 out of 100.
- Six states (Alabama, Delaware, Georgia, Oklahoma, Pennsylvania and Tennessee) still have an outdated requirement that harm to self or others be imminent for a person to qualify for inpatient commitment, and seven (Georgia, Ohio, Oklahoma, Oregon, Rhode Island, Wisconsin and Wyoming) require harm from failing to meet basic needs to be imminent to intervene.
- Five state laws contain no path to civil commitment for those who cannot meet their basic needs due to mental illness (Alabama, Delaware, District of Columbia, Maryland and New York).
- Three states still have no law allowing civil commitment to occur on an outpatient basis (AOT) (Connecticut, Maryland and Massachusetts).
- Tennessee’s AOT law is the only one written to prevent its use as an alternative to hospitalization.

The following recommendations are based on our analysis of the treatment laws in each state and identify key components of an ideally functioning system of mental illness treatment laws.

**POLICY RECOMMENDATIONS**

1. The time limit for an emergency hold should not be less than 72 hours with 48 hours as an absolute minimum.

2. Emergency evaluation laws should provide clear guidance for practitioners, law enforcement and families.

3. Any responsible adult or, at a minimum, a guardian or family member, should be authorized to petition the court for both emergency evaluation and inpatient civil commitment.

4. Criteria for danger to self should expressly include grave disability and psychiatric deterioration.

5. Criteria for grave disability should not require either unreasonably severe harm or for families to be required to deny assistance.

6. Criteria for psychiatric deterioration should allow consideration of treatment history and the likelihood of future psychiatric deterioration without treatment.

7. Criteria for danger to self or danger to others should not require imminent harm.
AOT criteria should allow consideration of at least three years of treatment history and must be suitable for outpatient use.

AOT criteria should not place unreasonable limitations on eligibility.

Any responsible adult or, at a minimum, guardians and family members should be authorized to petition the court for AOT.

AOT procedures should be described in sufficient detail to provide guidance to practitioners and to make maximum use of the “black robe effect.”

The duration for an initial AOT order should be a minimum of 90 days, and renewed orders should be for a minimum of 180 days.