Grave Disability, Basic Needs, and Welfare and Protection: Statutory Definitions for Involuntary Commitment Across States

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Objective: The authors aimed to identify and describe standards, across U.S. states and the District of Columbia (DC), for involuntary commitment of people experiencing a psychiatric disability that impairs their ability to live independently.

Methods: Statutes pertaining to involuntary commitment were compiled for all 50 states and DC. The authors focused on commitment criteria other than those regarding a person's danger to themselves or others and identified types and components of these standards, allowable evidence for meeting commitment standards, and other requirements and exclusions.

Results: Most jurisdictions (N=47) allowed for involuntary commitment of individuals experiencing one of three types of psychiatric disability: grave disability (12 states), inability to meet one's own basic needs (28 states), and inability to provide for one's own welfare and protection (nine states); two states used a combination of standards. Components of the standards, potential consequences of the specified condition, allowable evidence to establish the standard, exclusions, and requirements for consideration of treatment alternatives varied widely.

Conclusions: Involuntary commitment infringes fundamental liberties, and states were found to be inconsistent in the circumstances under which those liberties could be overridden to protect people who are unable to survive safely in the community. Further research is needed to help identify whether different types of standards more effectively allow for the provision of involuntary care to the individuals most likely to benefit from such care and how variations in statutory language affect rates of involuntary commitment.

Psychiatric Services 2026; 77:104–113;
doi: 10.1176/appi.ps.20240589

Involuntary commitment is a medicolegal intervention enabled by state law to provide hospitalization and treatment for people experiencing serious mental illness, such as schizophrenia or major depression, regardless of their refusal or inability to consent. Although legal reforms starting in the 1960s sought to limit involuntary psychiatric commitment to people who were dangerous to themselves or to others, in 1975, the Supreme Court ruled in *O'Connor v. Donaldson* that a nondangerous individual could be confined if not "capable of surviving safely in freedom by [them]self or with the help of willing and responsible family members or friends" (1). In this article, we refer to impairments in functioning that meet this criterion as "psychiatric disabilities."

Commitment criteria related to psychiatric disabilities have subsequently allowed for continued hospitalization of individuals deemed to need treatment but not meeting the more stringent dangerousness criteria (2, 3). Use of psychiatric disability criteria has declined recently as limited inpatient resources and more stringent insurance reimbursement requirements have restricted hospital care to those experiencing only the most acutely dangerous conditions (4–6). On the other hand, in the past decade,

HIGHLIGHTS

- Statutes in 47 states allowed involuntary commitment for grave disability, inability to meet one's own basic needs, or inability to ensure one's own welfare and protection.
- Standards for involuntary commitment differed in how they incorporated components of the standard, the potential consequences of the disability, evidence that could be considered, exclusions, and requirements for consideration of less restrictive alternatives to involuntary hospitalization.
- Understanding how involuntary commitment standards vary may facilitate research into the clinical and ethical implications of differing definitions of psychiatric disability, as well as the effects of these policy variations on patients and communities.

the statutory language concerning psychiatric disabilities has been amended in California, Idaho, Louisiana, Oregon, South Carolina, and Washington State (7–12).

Despite these ongoing shifts, the overall picture of current state laws enabling involuntary commitment for psychiatric disabilities remains unclear. A peer-reviewed evaluation of state inpatient commitment standards has not been published for nearly three decades (13, 14). The Treatment Advocacy Center (TAC) (15), a mental health lobbying organization, and LawAtlas (https://lawatlas.org/datasets/long-term-involuntary-commitment-laws) have identified the presence or absence of a psychiatric disability standard in all 50 U.S. states and the District of Columbia (DC) but have not examined the details of these standards. Other researchers have reviewed state laws concerning short-term emergency holds, involuntary outpatient treatment, involuntary commitment for substance use, police involvement in mental health transports, and the consequences of civil commitment for an individual's future access to firearms (16–20). However, none of these studies has addressed longer-term involuntary inpatient commitment or how statutes incorporate consideration of less restrictive alternatives.

In this study, we aimed to identify areas of commonality and variation in psychiatric disability statutes across jurisdictions. We focused on characterizing the overall type of standard used (e.g., basic needs) as well as the components (e.g., types of basic needs not being met) and potential consequences (e.g., risk of impairment) outlined in each standard. We also detailed the kinds of admissible evidence that could be used in evaluations and court proceedings, auxiliary criteria (e.g., a requirement to pursue treatment in the least restrictive setting), and inclusions and exclusions (e.g., diagnosis of a substance use disorder).

This article provides a baseline against which current and proposed legislative changes can be compared. Ambiguities and inconsistencies across jurisdictions that shape the balance between providing treatment and safeguarding a patient's rights are identified, and the need for research that elaborates clinical concepts of psychiatric disability is outlined. Although we did not examine how each state's psychiatric disability criteria were applied, we sought to facilitate future analyses of how variations in statutory language shape involuntary commitment in practice.

METHODS

To follow methodology from legal epidemiology (21, 22), we started by scoping the focal statutes of interest. We narrowed our analysis to the first nonemergency prolongation of an involuntary commitment after a temporary hold or detention. Nonemergency prolongation is a key passage in putting into place longer-term interventions to address psychiatric disabilities and is an area that has not been addressed by published mappings of commitment laws. We identified statutes by using TAC and LawAtlas data and cross-checked them through state legislative websites to ensure that the statutes were current as of June 1, 2024. We extracted the criteria specifying the conditions (e.g., lacking ability to fulfill basic needs) that had to be met in order to place a person under involuntary commitment, as well as any auxiliary requirements that had to be considered.

Legal epidemiology methodology entails structured coding that quantifies statutes reliably, with limited interpretation or judgment. Working iteratively, we developed a codebook of 56 variables, with examples of state statutes for each variable. The variables covered the presence or absence of a psychiatric disability criterion, diagnostic inclusions and exclusions, components of a disability, potential consequences that had to be identified for commitment, acceptable types of evidence, and additional required findings.

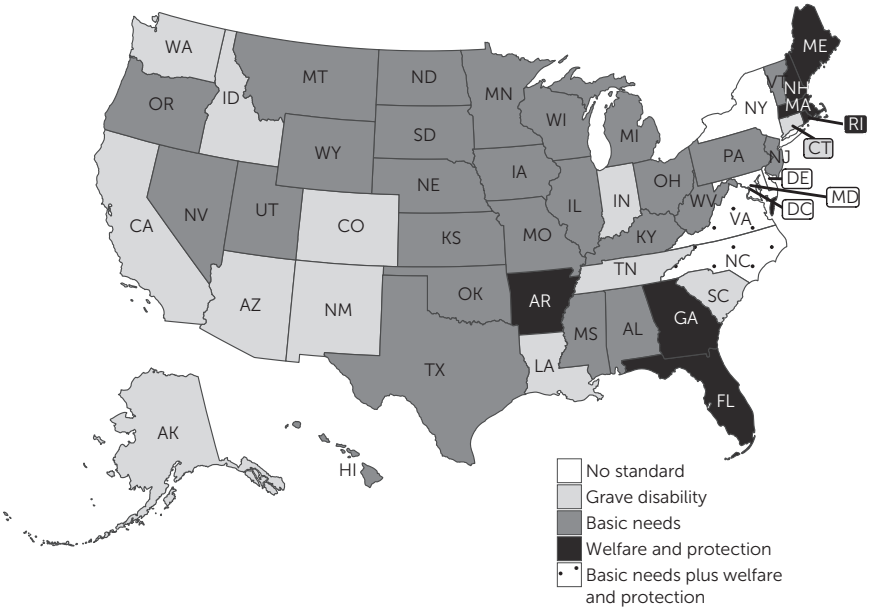
All five authors participated in coding. To ensure the quality of the data, we double-coded each state's statutes. Overall, the coders had 90% agreement. Some items (particularly those pertaining to temporality) had lower intercoder reliability. For example, agreement as to whether the statutes allowed involuntary commitment only for a current disability was 75%, and agreement as to whether the disability had to be identified on the basis of recent demonstrated or observed behavior was 73%. These lower agreement rates may have reflected fundamental ambiguities within the statutes. Discrepancies were reconciled through discussion. The codebook, examples, and final data are available on request from the corresponding author. Our research did not involve human subjects and was exempt from institutional review board approval.

RESULTS

All but four of the examined jurisdictions (DC, Delaware, Maryland, and New York) included a psychiatric disability criterion for involuntary inpatient commitment. Of the 47 states with a psychiatric disability criterion, 28 referred to the inability to meet one's own basic needs, 12 to a grave disability, and nine to the inability to provide for one's own welfare and protection. Two states (North Carolina and Virginia) had a criterion that referred to the inability to meet one's own basic needs together with the inability to provide for one's own welfare and protection (Figure 1).

Fourteen states also included a criterion for deterioration in a person's physical or mental state that was separate from dangerousness to self or others and from the grave disability, basic needs, or welfare and protection standards (see Figure S2 in the online supplement to this article). Grave disability, basic needs, or welfare and protection standards were usually written as a stand-alone criterion for commitment, separate from dangerousness to self or others. However, in 13 states, grave disability, basic needs, or welfare and protection standards were used to meet the criteria of dangerousness to self or others (see Figure S1 in the online supplement). Basic needs standards were included as a subset of dangerousness more frequently than were grave disability or welfare and protection standards

FIGURE 1. States' psychiatric disability standards, by type



The evidence that could be used to establish a psychiatric disability differed widely (Table 2). Seventeen states specified that grave disability, basic needs, or welfare and protection standards could be met only on the basis of a person's recent behavior. On the other hand, 21 states allowed consideration of past psychiatric disability, and four states' statutes (Arkansas, Iowa, North Carolina, and Oregon) could be interpreted as allowing for commitment solely on the basis of having met grave disability, basic needs, or welfare and protection standards in the past. Seventeen states were found to permit consideration of future or potential disability, and 13 states allowed for commitment solely on the basis of future or potential disability.

Most jurisdictions had additional prerequisites for involuntary commitment (Table 3). Many jurisdictions required that clinicians or courts consider and rule out less restrictive alternatives (N=38 states), involuntary outpatient treatment (N=23), or voluntary treatment or hospitalization (N=15). Fewer jurisdictions mentioned these three alternatives but did not require that they be considered or ruled out (N=3, N=14, and N=8, respectively). Other statutes mentioned or required a finding that a person lacked the capacity or ability to make treatment decisions (requirement, N=8; mention, N=17) or had turned down or refused other forms of treatment (requirement, N=2; mention, N=20); in total, nine required one or the other or both. Similarly, 15 states were found to incorporate consideration of a person's inability to make decisions about basic needs, with nine requiring this inability. Finally, 35 states required that a person needed or would benefit from treatment.

(N=11 of 28 states vs. N=0 of 12 and N=3 of 9, respectively). They were also more likely to co-occur alongside a deterioration standard (in N=11 of 28 states vs. N=1 of 12 and N=2 of 9, respectively).

The components used to define the grave disability, basic needs, and welfare and protection standards varied widely (Table 1). The most common components were the inability to provide for food or safety (N=29 states for both), followed by shelter (N=28). Fourteen states used a general, nondescript term (e.g., Indiana's "or other essential human needs") to indicate what the individual was unable to do, and seven of those states used a general term with no specific components. Two of the 47 states with a psychiatric disability criterion (Arkansas and Florida) specified no components at all. Forty-two states required that the inability to provide for these components stem from a mental illness or disorder, and five (Georgia, Hawaii, Massachusetts, North Carolina, and North Dakota) required that an illness or disorder be present without implying any necessary relationship between that condition and the grave disability, inability to meet one's own basic needs, or inability to provide for one's own welfare and protection.

In all but four states with a grave disability, basic needs, or welfare and protection standard (California, Idaho, Louisiana, and Montana), a psychiatric disability not only had to be present but also had to have a potentially negative consequence to qualify an individual for involuntary commitment. The most common consequence was physical injury or harm (N=38 states), followed by impairment or disability (N=17) and death or suicide (N=16). Fewer states included illness or disease (N=12), psychiatric or psychological harm (N=8), loss of functioning or independence (N=5), or harm to others or to property (N=3). Sixteen states required imminent negative consequences.

Previous reviews (19) have found substance use disorder commitment statutes in 37 states. However, we found that only 16 states explicitly specified the presence of a substance use disorder as meeting the grave disability, basic needs, or welfare and protection standard, and 19 states expressly prohibited commitment on the basis of these standards if solely caused by substance use (see Figure S3 in the online supplement). The remaining 16 jurisdictions made no definitive reference as to whether a substance use disorder could qualify a person for involuntary psychiatric commitment.

Thirty-three states had other diagnostic exclusions, such as developmental or intellectual disabilities, personality disorders, neurocognitive disorders (e.g., Alzheimer's disease), and general medical disorders (e.g., epilepsy and traumatic brain injury) (Table 4). Fewer states exempted from involuntary commitment people who were solely experiencing brief periods of intoxication (N=10 states); whose needs could

TABLE 1. Components of the standards of grave disability, basic needs, and welfare and protection used to define the psychiatric disability criterion of involuntary commitment statutes, by state

State	Inability to provide for								Requires potential negative consequence[b]	Requires imminent negative consequence
	Food, nourishment, or nutrition	Shelter or housing	Clothing	Personal safety	Medical care	Physical health	Mental health care	Nonspecific term or unspecified[a]		
AL	✓	✓		✓	✓				✓	
AK	✓	✓	✓	✓					✓	
AZ								✓	✓	
AR									✓	
CA	✓	✓	✓	✓	✓					
CO								✓	✓	
CT	✓	✓	✓	✓					✓	
DE										
DC										
FL									✓	✓
GA				✓		✓			✓	✓
HI	✓	✓		✓	✓		✓		✓	✓
ID	✓	✓	✓	✓	✓					
IL				✓				✓	✓	
IN	✓	✓	✓					✓	✓	
IA	✓	✓	✓		✓				✓	
KS	✓	✓	✓	✓		✓			✓	
KY	✓	✓	✓						✓	
LA	✓	✓	✓	✓	✓					
ME				✓					✓	
MD										
MA				✓					✓	
MI	✓	✓	✓						✓	✓
MN	✓	✓	✓		✓				✓	
MS	✓	✓	✓		✓				✓	
MO	✓	✓	✓	✓	✓		✓		✓	
MT	✓	✓	✓	✓		✓				
NE	✓	✓	✓	✓	✓				✓	✓
NV	✓	✓	✓	✓					✓	
NH								✓	✓	
NJ	✓	✓			✓				✓	✓
NM				✓	✓			✓	✓	✓
NY										
NC	✓	✓		✓	✓			✓	✓	✓
ND	✓	✓						✓	✓	
OH								✓	✓	✓
OK								✓	✓	✓
OR								✓	✓	✓
PA	✓	✓		✓	✓				✓	✓
RI				✓		✓		✓	✓	
SC								✓	✓	
SD	✓	✓	✓	✓	✓				✓	✓
TN				✓		✓			✓	
TX	✓		✓	✓		✓			✓	
UT	✓	✓	✓						✓	
VT	✓	✓		✓	✓				✓	
VA				✓				✓	✓	✓
WA				✓		✓			✓	
WV	✓	✓		✓	✓				✓	
WI	✓	✓		✓	✓				✓	✓
WY	✓	✓		✓	✓				✓	✓

[a] Includes states that use a general term (e.g., "basic needs") alongside more specific ones (e.g., "food" or "shelter"), as well as states that offer no definition of the key construct (e.g., "lacks the capacity to care for own welfare").

[b] Potential consequences could include death, suicide, physical injury or harm, impairment or disability, psychological or psychiatric harm or deterioration, illness or disease, loss of functioning or independence, or harm to others or property as a result of a psychiatric disability.

be provided by a third party, such as a family member (N=8); whose behavior was related to criminal activity (N=7); who were unable to meet their basic needs because of indigence or homelessness (N=4); or who were receiving treatment via spiritual or religious practices (N=3).

TABLE 2. Temporality and allowable evidence of the psychiatric disability standards of grave disability, basic needs, and welfare and protection, by state

State	Present		Past		Future	
	Person must currently meet standard	Standard must be established on the basis of recent demonstrated or observed behavior	History of impairment or treatment response may be considered	Standard may be met on the basis of history alone	Potential deterioration in a person's physical or mental state may be considered	Standard may be met on the basis of potential deterioration alone
AL		✓	✓		✓	✓
AK	✓					
AZ	✓	✓				
AR			✓	✓	✓	✓
CA	✓		✓			
CO	✓					
CT	✓					
DE						
DC						
FL	✓					
GA	✓					
HI	✓	✓				
ID					✓	✓
IL			✓		✓	✓
IN	✓					
IA	✓		✓	✓	✓	✓
KS	✓					
KY	✓					
LA	✓					
ME		✓	✓		✓	
MD						
MA					✓	✓
MI		✓			✓	✓
MN	✓					
MS	✓					
MO	✓		✓			
MT			✓		✓	✓
NE	✓					
NV	✓					
NH	✓	✓	✓			
NJ			✓			
NM	✓					
NY						
NC	✓		✓	✓	✓	
ND	✓		✓		✓	✓
OH	✓					
OK	✓	✓	✓			
OR			✓	✓	✓	✓
PA	✓	✓				
RI	✓		✓			
SC	✓					
SD		✓	✓		✓	✓
TN		✓			✓	✓
TX	✓	✓	✓		✓	
UT	✓	✓				
VT		✓			✓	✓
VA	✓		✓			
WA	✓	✓	✓		✓	
WV	✓	✓	✓			
WI		✓	✓			
WY	✓	✓				

DISCUSSION

Above, we have provided a detailed analysis of the criteria for involuntary inpatient commitment because of psychiatric disability across the 50 states and DC. We found several points of relative consensus. Most of the states (N=47) included a clause identifying grave disability, inability to provide for one's own basic needs, or inability to ensure one's own welfare and protection as a basis for involuntary

TABLE 3. Alternatives and auxiliary requirements with regard to the psychiatric disability criterion, by jurisdiction

State	Evaluation for or ruling out of			Auxiliary requirement			
	Less restrictive alternative[a]	Involuntary outpatient treatment[a]	Voluntary outpatient treatment or hospitalization[a]	Declined offer of voluntary, less restrictive, or outpatient treatment[a–c]	Lacks capacity to make decisions about treatment[a,c,d]	Lacks capacity to make decisions about basic needs or welfare[a,d]	Needs or will benefit from treatment
AL	X	X			X		✓
AK	/		/	/			
AZ	X	X	X	/	/		✓
AR	/	/	/	/	/	X	
CA			X	/	/		
CO			X	/		X	
CT	X		X	X	X		✓
DE	X		X	/	/		
DC	X						
FL	X	/	X	/	/		✓
GA		/					✓
HI	X						✓
ID	X	/			/		✓
IL	X	/	/	/	/		✓
IN		/				/	✓
IA		/			X		
KS		/			X		✓
KY	X	/					✓
LA	X						✓
ME	X	X	/	/	/		
MD	X		X	/	/		✓
MA						X	
MI	X	X	X	/	/		✓
MN	X	X	X	/			✓
MS	X	X	X				✓
MO	X	X			X		
MT	X	X					
NE	X	X	X				
NV	X	X				X	✓
NH	/	/		/		X	✓
NJ	X	X	X	X			✓
NM	X						✓
NY	X				X		✓
NC		X				X	✓
ND					/	X	✓
OH	X	/	/	/			
OK	X	X					✓
OR	X	X	X	/	/		✓
PA	X	X				/	✓
RI	X	X	X			/	✓
SC		/			X		✓
SD	X	/		/	/		✓
TN	X					/	✓
TX	X	X			X		
UT	X	/	/	/	/		✓
VT	X	X				X	✓
VA	X	X	X	/	/	X	
WA	X	X	/	/	/	/	
WV	X	X					✓
WI	X	X	/	/	/	/	✓
WY	X	X					✓

[a] For this column, "X" denotes that an element is required for commitment, and "/" denotes that an element is incorporated into the standard but not explicitly required for commitment.
[b] The indicated states require evidence that the person has declined, refused, or is unwilling to accept less restrictive alternatives.
[c] States that have an "X" or "/" in both columns require the person to have declined an offer of less restrictive, voluntary, or outpatient treatment or to lack the capacity, judgment, ability, or insight to make decisions.
[d] The statutes of the indicated states mention a patient lacking capacity, ability, judgment, or insight.

commitment. This number was larger than that identified by LawAtlas in 2016 (N=32), possibly reflecting legislative changes, methodological differences, or our inclusion of welfare and protection standards. The present findings indicate the continuing relevance of parens patriae—the state's role in caring for persons who are vulnerable as a result of mental illness—as a justification for involuntary commitment, alongside the dangerousness criterion. The statutes were also largely consistent in requiring that the inability to provide for one's own needs or welfare results from a mental illness and has a potentially harmful consequence. Most of the states mandated the consideration of less restrictive alternatives to involuntary inpatient commitment.

Because involuntary commitment denies people their fundamental civil liberties, however, more attention is needed to points of high variability between jurisdictions. For example, fewer than half of the states explicitly incorporated a reference to needing to consider (and a person having turned down) voluntary hospitalization or outpatient treatment. The statutes thus may not protect against situations in which a person would accept an offer of voluntary treatment but is nonetheless involuntarily committed because of a lack of systemic capacity to provide these alternatives. In addition, we identified wide variation in the illnesses, conditions, and circumstances that could exempt an individual from or subject them to commitment. Given concerns about racial-ethnic disparities in the use of involuntary psychiatric interventions (23–26), and because certain components of the grave disability, basic needs, and welfare and protection standards (e.g., a lack of shelter or personal safety) can result from structural exclusion as well as from mental illness, conscientiously specifying protections against and indications for commitment is essential to advancing health equity.

Some of this variation may have reflected fundamentally different, if unarticulated, understandings of what serves as a basis for involuntary commitment. Although there is no consistent definition of grave disability, the wording of this standard implies the presence of a clinical syndrome that impairs functioning. An inability to meet basic needs refers to a list of behaviors. Welfare and protection standards express a broader state of vulnerability. Defining grave disability as a distinct clinical syndrome suggests that treatment for gravely disabled individuals may differ from the treatment for those deemed acutely dangerous (6). For example, researchers have shown that some individuals with a grave disability can be placed directly in unlocked, structured housing without an acute inpatient stay (27). Others have argued that, because of a lack of effective options for individuals with treatment-resistant conditions and grave disability, involuntary commitment in these cases should be replaced with palliative psychiatry (28). Additional research is needed to explore whether specific interventions can address an inability to meet basic needs or to provide for one's own welfare or protection.

State-level variation in commitment standards may result from, and reinforce, the lack of reliable clinical definitions of psychiatric disabilities. Scales to evaluate grave disability were developed in the 1980s and have been shown to correlate with other measures of clinical need and to reliably predict admission decisions (29, 30). However, these scales were validated with respect to the specific statutes of California and may not apply in states with different components (such as commitment for substance use or consideration of future deterioration of a person's mental or physical state). These scales have not been updated to account for changes in law, psychiatric training, or systems organization, and they do not appear to be currently used in research or clinical practice.

Enormous growth in neuropsychological research on functional deficits in psychotic disorders (31) has occurred, but this growth has not been matched by attention to the phenomenology underlying the grave disability, basic needs, and welfare and protection standards. Clinical designations, such as treatment-resistant schizophrenia or complex psychosis, do not specify symptomatic or behavioral criteria or a severity threshold beyond which involuntary treatment is indicated (32, 33). Questions remain regarding whether involuntary commitment statutes are sufficiently clear to reliably guide treatment decisions and about the training of clinicians in how to interpret these laws (34, 35).

Indeed, our findings confirm that commitment statutes contain numerous ambiguities. Sixteen jurisdictions provided no indication of whether substance use–related conditions could lead to commitment under the grave disability, basic needs, and welfare and protection standards. Despite multiple iterations of codebook development, our paired coders disagreed 25% of the time as to whether a statute required that a person have a current disability to meet the state's standard for commitment. Furthermore, our coding suggested that four states' statutes could be used to commit an individual solely on the basis of historical psychiatric disability, regardless of a person's current status. States also relied heavily on vague or ill-defined components and consequences (e.g., "essential personal needs" or "harm") and varied with regard to whether they used clinical or lay terminology (e.g., "lack of capacity" vs. "poor judgment" to make decisions). The existing research has shown wide divergence in how clinicians and judges apply criteria such as dangerousness, even though statutory language regarding and clinical definitions of dangerousness have been more consistent compared with those for the grave disability, basic needs, and welfare and protection standards (36–38). We thus suspect that these ambiguities in psychiatric disability criteria have resulted in inconsistent use of involuntary commitment. However, our review of the literature identified no systematic investigations of variance in the implementation of grave disability, basic needs, and welfare and protection standards across states.

We did not attempt to rank jurisdictions on the expansiveness or restrictiveness of their commitment statutes, as have advocacy groups such as TAC (15). We found no consistent

TABLE 4. Exclusions to the psychiatric disability criterion as defined by the standards of grave disability, inability to meet one's own basic needs, or inability to provide for one's own welfare and protection

Exclusion	State
Diagnostic	
Developmental or intellectual disability	AL, AK, AZ, AR, CA, CO, FL, ID, IL, IA, KS, LA, ME, MD, MN, MO, MT, NV, NH, NM, ND, OK, SD, TN, TX, VT, WA, WY
Neurocognitive disorder (e.g., dementia)	AZ, FL, ID, IL, KS, MD, MI, MS, MO, MT, NV, OK, TX, WA, WI
Personality disorder	AZ, FL, IL, KS, ME, WV
General medical disorder (e.g., epilepsy, traumatic brain injury)	AL, AK, AR, FL, ID, KS, LA, MI, MN, MS, MO, MT, NV, NH, NJ, OK, SD, TX, WI
Other	
Provision for basic needs by third party	CA, ID, MA, NJ, NC, OH, OR, WY
Criminal behavior or history	AZ, FL, IL, IA, SD, TX, WV
Treatment via spiritual or religious practice	ID, KS, OH
Indigence or homelessness	KS, MN, OK, TX
Temporary intoxication	AR, FL, MN, MS, MO, MT, NV, NH, SD, WY

clustering or relationships across the different dimensions of our coding. In some states, lawmakers have sought to reform grave disability, basic needs, and welfare and protection standards, with the assumption that additional components would better address the long-term needs of people experiencing combined chronic psychosis and homelessness (39, 40). However, 28 states already explicitly incorporate the inability to provide for one's own shelter in their standard, and 11 additional states included a catch-all term that could include it. Prior to enacting reform, comparative research should address whether these inclusions affect the rates of homelessness, alongside other factors such as housing availability and the specific dimensions of psychiatric disabilities that shape a person's ability to obtain and maintain housing. In 2019, the Substance Abuse and Mental Health Services Administration (41) outlined a principles-based approach to civil commitment, which could be used to evaluate psychiatric disability standards. For example, the principle of "respect for autonomy" suggests the importance of including an offer of voluntary treatment, whereas the standard of "avoiding harm/advancing best interests" might be met by requiring high risk for negative consequences (e.g., harm to self or others or death) before commitment. Better evidence about the use and impacts of specific components of psychiatric disability standards would facilitate ethical deliberation about the criteria that would best support these principles.

Our study had three key limitations. First, we did not examine how the statutes were applied in practice. The data on involuntary commitment were limited (42): a recent state-by-state review identified a usable number of emergency holds for only 25 states, and its authors could not provide a breakdown of the prevalence of various indications for commitment (e.g., danger to the self or grave disability) (43). Prior research (44–46) has offered conflicting conclusions about whether reforms to statutes alter rates of commitment, absent other changes such as increased psychiatric bed availability. Consequently, we cannot know whether aspects of statutory language (e.g., ambiguous vs. explicit, parsimonious vs. expansive, encouraging consideration of less restrictive alternatives vs. requiring they be ruled out) affect the frequency or appropriateness of involuntary commitment. However, a clear portrait of legal variation is a crucial foundation for subsequent analyses of the effects of these statutes.

Second, we focused only on statutory language. In New York State and DC, appellate courts have articulated a basic needs criterion for commitment, despite its absence in the statutes (47, 48). Moreover, in Portland, OR, and in New York City, local leaders have called for municipal law enforcement officers to alter their use of the grave disability, basic needs, and welfare and protection standards in emergency holds (49). Court decisions, regulatory directives, policies of local behavioral health departments, and professional norms may alter the use of these standards, but their impacts on client care and due process have received little attention. This area represents an important gap in the literature.

Finally, although these statutes change infrequently (only six states had updated their psychiatric disability criteria in the decade prior to our study), our work provides a baseline that is current as of June 1, 2024, but may need updating. For example, in 2025, the New York State legislature formalized the existing standard from case law regarding an inability to meet one's own basic needs (50).

CONCLUSIONS

Fifty years ago, *O'Connor v. Donaldson* limited involuntary commitment to people who were dangerous to themselves, dangerous to others, or unable to survive safely in the community. States have operationalized the psychiatric disabilities that interfere with a person's ability to survive safely in disparate ways. This study's results provided a portrait of variation in the criteria, evidence, exclusions, and alternatives considered in grave disability, basic needs, and welfare and protection standards within involuntary commitment statutes across the country. Further research is needed to identify state-level impacts of specific statutes on the frequency and appropriateness of commitments, as well as to conceptualize and characterize the clinical conditions associated with the psychiatric disabilities that commitment statutes aim to address.

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A previous version of this study was presented at the annual meeting of the American Psychiatric Association, Los Angeles, May 17–21, 2025.

The authors thank Rick Orlina, Ph.D., for help in preparing figures.

The authors report no financial relationships with commercial interests.

Received December 3, 2024; revision received May 21, 2025; accepted September 17, 2025; published online December 11, 2025.

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