

## **A General Description Of An Involuntary Hold Process For Mentally Ill Patients**

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I began reflecting on what a good counselor would do in a case when someone is experiencing hearing voices, in what we know as a “psychotic break” from reality.

How would a mental health clinician normally deal with this issue? If I were in a crisis unit, say, for the California county I worked in, I would diagnose someone, then decide whether they should be involuntarily hospitalized or not, in what we called a “5150”. A 5150 is a 3-day hold, where they are involuntarily locked up in a psych unit of some kind, such as at a state psychiatric hospital.

In California this is known as a “5150” of a person; in Ohio it was called a “pink slip”, for some reason. I did not think that was funny. This was no employment the person was being fired from; it was being taken out of mainstream life, locked up for three days (72 hours) against their will, unable to talk to anyone they knew.

The hospital would make sure they were seen by a psychiatrist, who usually would prescribe them medications. Often these people were “off their meds” and had to be “restabilized”, before they went home.

Often, after the 72-hour involuntary hold, the patient would be brought to a Re-certification hearing, which is a mental health court held at the hospital in a private room, which had a judge who would review the information and decide whether the patient was stable and could go home. Often the judge was an attorney specially trained for this job.

A long table would have the patient and their Patient's Right's Advocate sitting next to them, and on the other side of the table sat the hospital representative who presented their case for keeping the patient in the hospital for another two weeks. The Patient's Right's Advocate would also present their case, following a standard protocol of speaking with people involved with the Patient's care, and their families or friends, or whoever they would stay with if they were released that day.

California law states that patient's cannot be released to the sidewalk, they must have a place to live, where food was provided, and there was a way to provide hygiene care and basic needs of life. Did the patient have income, did they have disability? How would they support themselves? Was someone there at their home who could take care of them? These questions had to be answered along with how well the patient had followed the hospital program rules, how willing they were to take their meds, and how effective the meds were working.

The hospital representative would present their case, in which they would read the doctor's notes, speaking on the doctor's behalf about whether the doctor felt the patient was ready to go home, and what the staff had written in their observations, discussions and interactions with the patient. Both sides had case notes and presented their facts to the judge who sat at the head of the table. After hearing all the facts, and asking the patient several questions, the judge would make a decision whether the patient went home. Often the patient was held for another two weeks, involuntarily, called a "5250" hold.

Eventually, when the patient's were released, they would have been seen by the Discharge planner at the hospital who had the resources for basic daily needs, in case patient's needed these resources. The Discharge planner could also refer them to counselor's or treatment programs to continue on in their treatment. Resources a patient might need were often related to their housing, transportation, getting meds paid for, what health insurance would cover the cost of the medications and any treatment needed.

