Observation Hold

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Observation Hold

Primary Disciplinary Field(s): Law Enforcement, Mental Health Law, Psychiatry, Emergency Medicine

1. Core Definition

The **observation hold** represents a critical, time-limited intervention employed within both law enforcement and medical frameworks, designed to facilitate an immediate and intensive assessment of an individual's mental state. Its primary objective is to ascertain whether a person, particularly one who has been taken into custody or is presenting with acute behavioral disturbances, is experiencing a mental health crisis or exhibiting symptoms indicative of a severe mental illness that necessitates psychiatric intervention. This practice operates on the premise that certain behaviors or threats, such as those involving self-harm or harm to others, may stem from underlying mental health issues rather than purely criminal intent or conscious decision-making. Consequently, an observation hold allows for a temporary suspension of immediate legal processing or release, prioritizing a comprehensive psychiatric evaluation in a secure and appropriate clinical setting. This initial period is crucial for differentiating between transient distress, substance-induced psychosis, or a genuine psychiatric emergency, guiding subsequent decisions regarding the individual's welfare and legal status.

During an observation hold, the individual is typically placed within a specialized mental health facility, such as a psychiatric unit within a hospital or an emergency psychiatric assessment center. This placement is distinct from a correctional facility, emphasizing the medical rather than punitive nature of the intervention. The duration of such a hold is strictly regulated by jurisdictional laws, but commonly extends for a period of up to 72 hours. This timeframe is generally considered sufficient for mental health professionals, including psychiatrists, psychologists, social workers, and nurses, to conduct thorough observations of behavior, thought patterns, emotional regulation, and overall mental status. The process involves continuous monitoring, structured interviews, and often collaboration with family members or other involved parties to gather collateral information, all aimed at formulating an accurate clinical picture and determining the most appropriate next steps for care and disposition.

The concept of an observation hold underscores a societal commitment to addressing mental health concerns proactively, especially when individuals are in acute distress or pose potential risks to themselves or others. It serves as a vital bridge between immediate crisis response, often initiated by law enforcement, and the specialized care provided by the mental health system. By providing a structured period for assessment, it seeks to ensure that individuals in vulnerable states receive appropriate medical attention, preventing potential escalation of mental health crises and facilitating pathways to recovery, rather than defaulting to incarceration for behaviors that may

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be symptoms of illness. This nuanced approach recognizes the complex interplay between legal statutes, ethical obligations, and the imperative to provide humane and effective care during moments of profound psychological vulnerability.

2. Etymology and Historical Development

The precise etymology of the term "observation hold" is closely linked to the evolving legal and medical lexicon surrounding involuntary psychiatric evaluation and crisis intervention. While not a term with ancient roots, its conceptual underpinnings can be traced to the historical recognition that individuals in acute mental distress might pose risks to themselves or others, necessitating temporary detention for assessment and protection. Historically, responses to such crises often involved commitment to asylums, a practice that, while intended for care, was frequently criticized for its indefinite nature and lack of due process. The mid-20th century, however, witnessed significant shifts in mental health policy, driven by advocacy for patients' rights, the development of psychopharmacology, and the broader movement of deinstitutionalization. These changes sought to move away from long-term institutionalization towards community-based care and shorter, more acute interventions.

The development of specific legal provisions for emergency psychiatric holds, often referred to by various names such as "72-hour hold," "emergency detention," or "involuntary psychiatric hold" (e.g., California's Welfare and Institutions Code 5150), emerged as a direct response to these evolving ethical and clinical standards. These legal frameworks codified the authority for designated professionals, including law enforcement officers and mental health practitioners, to initiate a temporary, involuntary detention for psychiatric evaluation when an individual is deemed a danger to self, danger to others, or gravely disabled due to a mental disorder. The "observation" aspect explicitly emphasizes the assessment phase, distinguishing it from a commitment for long-term treatment. It arose from the understanding that immediate, intensive assessment could prevent unnecessary long-term commitments while ensuring those in genuine crisis received timely care.

The modern application of the observation hold, therefore, represents a maturation of legal and clinical thought. It moved from a punitive or purely custodial approach to one that prioritizes rapid psychiatric assessment. The emphasis on a defined, limited duration, such as the 72-hour standard common in many jurisdictions, reflects a balance between the need for thorough clinical evaluation and the protection of individual liberties, ensuring that individuals are not held indefinitely without formal review. This evolution reflects a continuous effort to refine mental health crisis response, integrating legal authority with clinical expertise to provide humane and effective interventions for individuals experiencing acute psychological distress. It acknowledges the inherent tension between coercive intervention and individual autonomy, aiming to resolve it through structured, temporary assessment.

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3. Key Characteristics

The practice of an observation hold is defined by several core characteristics that distinguish it from other forms of detention or medical intervention. Firstly, its **time-limited nature** is paramount. While specific durations vary by jurisdiction, a common benchmark is a 72-hour period, during which the individual is held for observation and evaluation rather than indefinite confinement. This finite timeframe is legally stipulated, balancing the imperative for comprehensive assessment with the protection of individual liberties against arbitrary detention. The clock for this period typically begins upon the individual's arrival at the designated mental health facility, emphasizing a focused and expedited assessment process designed to reach a preliminary clinical determination within these statutory limits.

Secondly, the **primary purpose is diagnostic and evaluative**, not punitive or therapeutic in the long-term sense. The goal is to determine the presence and severity of a mental health condition that warrants involuntary treatment or continued care, or conversely, to establish that such conditions are not present to a degree requiring involuntary measures. This involves a multidisciplinary team conducting thorough observations of behavior, cognitive function, emotional state, and the presence of any psychotic symptoms. The focus remains on gathering sufficient clinical data to inform a judicious decision about the individual's capacity for self-care and safety. The observation period is explicitly structured to allow for the dynamic nature of mental health crises, where initial presentations may evolve or resolve.

Thirdly, an observation hold typically involves **involuntary detention**, meaning the individual does not consent to the confinement, although they are generally offered voluntary treatment options. This involuntary aspect necessitates a legal basis, usually predicated on specific criteria such as being a danger to oneself (e.g., active suicidal ideation or attempts), a danger to others (e.g., threats or acts of violence), or being gravely disabled (e.g., unable to provide for basic needs due to mental illness). These criteria must be clearly articulated and met for the hold to be legally initiated and maintained, ensuring that coercive measures are only applied when absolutely necessary to protect the individual or the community.

Finally, the intervention is inherently **multidisciplinary and collaborative**, bridging law enforcement and mental health services. Law enforcement often initiates the process in response to a crisis, transporting the individual to a medical facility. Once there, mental health professionals assume responsibility for the clinical assessment. This seamless transition and collaboration are crucial for the effectiveness of the observation hold, ensuring that individuals in acute crisis receive appropriate care without falling through the gaps between different public service sectors. The process requires clear communication and understanding of each other's roles and limitations, from initial encounter to final disposition.

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4. Significance and Impact

The observation hold plays a profoundly significant role in contemporary public safety and mental health policy, acting as a crucial safety net for individuals experiencing acute psychiatric crises. Its primary impact lies in its ability to facilitate **early intervention** for severe mental health conditions, often at a point when individuals are most vulnerable and least capable of seeking help voluntarily. By providing a structured and legally sanctioned pathway for immediate assessment, it can prevent tragic outcomes such as suicide, serious self-harm, or violence towards others, which might otherwise occur if individuals were left unaided or only subjected to criminal justice processes. This proactive approach underscores a societal shift towards recognizing mental health crises as medical emergencies requiring specialized care, rather than solely as matters for law enforcement.

Furthermore, observation holds serve as a vital mechanism for **de-escalating crises** and diverting individuals from the criminal justice system when their behaviors stem from mental illness rather than malicious intent. As illustrated by the example of someone barricading themselves and threatening suicide, law enforcement's initial response may lead to custody, but the observation hold directs the individual towards clinical evaluation. This prevents the unnecessary criminalization of mental illness and offers a more appropriate and humane response. It acknowledges that jailing someone experiencing a psychotic episode or severe depression is not only ineffective for their mental health but also strains correctional resources that are ill-equipped to provide psychiatric care. The impact here is twofold: better outcomes for individuals and more efficient use of public resources.

The impact extends to **protecting individual rights while ensuring public safety**. While involuntary, the time-limited nature and requirement for clinical assessment provide a degree of protection against indefinite detention without cause, a criticism often leveled against historical asylum practices. It mandates a professional review of the individual's mental state, offering a safeguard against arbitrary confinement and ensuring that decisions are based on clinical evidence rather than speculation or prejudice. For communities, the observation hold contributes to public safety by enabling swift intervention when individuals pose a risk, ensuring that those who are unstable receive the necessary assessment to mitigate potential harm to themselves or others, thereby fostering a more secure environment for all.

Ultimately, the widespread implementation of observation holds has significantly influenced the landscape of mental health crisis response, fostering greater collaboration between emergency services and mental health providers. It has helped to institutionalize a more compassionate and clinically informed approach to individuals in acute distress, recognizing their behaviors as potential symptoms of illness rather than purely volitional acts. This has had a transformative impact on how society views and responds to mental health emergencies, moving towards a model of care that prioritizes assessment, stabilization, and appropriate referral to further treatment, rather than

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immediate punishment or indefinite institutionalization.

5. Debates and Criticisms

Despite its vital role, the practice of an observation hold is not without its share of debates and criticisms, often stemming from the inherent tension between individual liberty and the state's responsibility to protect its citizens and vulnerable individuals. A primary concern revolves around **due process and individual autonomy**. Critics argue that involuntary detention, even for a limited period, represents a significant infringement on a person's freedom and constitutional rights. While legal frameworks typically require specific criteria (danger to self/others, grave disability), the subjective nature of mental health assessment can lead to concerns about potential misuse or misinterpretation of these criteria, particularly in high-stress situations. There are debates about whether individuals are adequately informed of their rights during such a crisis and if there are sufficient safeguards against wrongful holds.

Another significant criticism centers on **resource limitations and the quality of care** during the observation period. Mental health facilities, especially emergency departments and psychiatric units, are often overburdened, leading to concerns about adequate staffing, bed availability, and the environment in which observations occur. A lack of specialized beds can result in individuals being held in emergency rooms for extended periods, which is not conducive to proper psychiatric assessment and can exacerbate their distress. Critics also question whether a 72-hour period is truly sufficient for a comprehensive diagnosis, particularly for complex mental health conditions, arguing that this brevity might lead to superficial assessments and premature release or inappropriate referrals. The quality of follow-up care after the hold is also a common point of contention, as a successful observation hold needs to lead to effective ongoing treatment.

Furthermore, there are ethical dilemmas concerning the **coercive nature of the intervention**. Even when justified by clinical necessity, the involuntary aspect can be traumatizing for individuals, potentially eroding trust in mental health professionals and making them less likely to engage in future voluntary treatment. This tension is particularly acute for individuals from marginalized communities who may have historical reasons to distrust state interventions. The potential for racial or socioeconomic biases in the application of observation holds is also a recurring concern, with studies sometimes indicating disproportionate impacts on certain demographic groups, raising questions about equitable access to mental health support versus coercive measures.

Finally, debates persist regarding the **interface between law enforcement and mental health services**. While collaboration is essential, concerns are sometimes raised about the extent to which law enforcement officers are adequately trained to recognize mental health crises versus criminal behavior, and whether their initial assessment always leads to the most appropriate pathway. There are calls for greater involvement of mental health professionals in crisis response

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teams, reducing the reliance on police as primary responders in non-violent mental health emergencies. These criticisms highlight the ongoing need for refinement in policy, training, and resource allocation to ensure that observation holds are applied justly, effectively, and with the utmost respect for individual dignity and rights.

6. Legal Frameworks and Jurisdictional Variation

The legal foundation for an observation hold is intricate and varies significantly across different jurisdictions, both within federal systems like the United States and internationally. While the core principle of temporary involuntary psychiatric assessment remains consistent, the specific statutes, criteria for initiation, duration, and appeal processes can differ substantially. In the United States, for instance, these provisions are typically found within state mental hygiene laws or welfare and institutions codes. A prominent example is California's Welfare and Institutions Code Section 5150, which authorizes a 72-hour involuntary hold for evaluation and treatment for individuals who are a danger to themselves, a danger to others, or gravely disabled due to a mental disorder. Similar statutes exist in other states under different nomenclatures, such as a "Section 12" in Massachusetts or "Form 1" in Ontario, Canada, each with its own precise legal language and procedural requirements.

These legal frameworks delineate who has the authority to initiate an observation hold. Commonly, this includes certified mental health professionals (e.g., psychiatrists, psychologists, licensed clinical social workers), designated emergency medical personnel, and, critically, law enforcement officers. The criteria for initiating a hold are strictly defined to prevent arbitrary detention, requiring demonstrable evidence that the individual meets the "danger to self," "danger to others," or "gravely disabled" thresholds. The interpretation and application of these criteria are often subject to judicial review and are informed by evolving clinical standards, ensuring that the intervention is not only legally permissible but also clinically warranted. The legal process usually mandates that individuals be transported to a psychiatric facility that is licensed to conduct such evaluations, thereby ensuring a clinical environment for assessment.

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Further variation exists in the procedural safeguards and subsequent legal steps after the initial hold. Many jurisdictions require a prompt psychiatric evaluation following admission, and if continued detention is deemed necessary beyond the initial observation period, a formal court order or an administrative hearing might be required. This usually involves a higher legal standard of proof and provides the individual with the right to legal representation and to challenge the involuntary commitment. For instance, after a 72-hour hold, an individual might be placed on a longer hold (e.g., 14-day hold) only if the criteria for continued involuntary treatment are rigorously met and reviewed by a court or administrative panel. This tiered approach to involuntary commitment reflects a continuous effort to balance the need for public safety and clinical intervention with the fundamental rights of individuals.

The legal complexity underscores the necessity for extensive training for all professionals involved, from the patrol officer on the street to the emergency room physician and the psychiatric social worker. Understanding the specific legal statutes, the precise criteria, and the procedural requirements of their jurisdiction is paramount to ensure that observation holds are initiated and managed lawfully and ethically. This mosaic of legal provisions highlights the societal challenge of developing effective and humane responses to mental health crises, continuously striving to refine laws that protect both individual autonomy and collective well-being in moments of extreme vulnerability.

7. Clinical Assessment and Protocols

The clinical assessment during an observation hold is a highly structured and multidisciplinary process, guided by established psychiatric protocols and best practices. The primary goal is to conduct a thorough and rapid evaluation of the individual's mental status, behavior, and risk factors to inform a disposition decision within the legally mandated timeframe. Upon admission to a psychiatric emergency service or an inpatient observation unit, a comprehensive assessment typically begins with a detailed medical evaluation to rule out any underlying physical conditions or substance intoxication that might mimic psychiatric symptoms. This initial medical clearance is crucial, as many acute behavioral changes can be attributed to non-psychiatric causes, such as metabolic imbalances, infections, or adverse drug reactions.

Following medical clearance, a core team of mental health professionals--which may include psychiatrists, psychiatric residents, nurse practitioners, social workers, and mental health technicians--commences the psychiatric assessment. This involves observing the individual's presentation, affect, thought processes, speech patterns, and interactions. Structured interviews are conducted to gather information about their current symptoms, past psychiatric history, substance use history, social support network, and any history of violence or self-harm. Crucially, collateral information from family members, friends, or the referring law enforcement officers is often sought and integrated, as individuals in acute mental health crises may lack insight into their condition or provide unreliable accounts. This holistic approach ensures a more complete and accurate understanding of the individual's clinical picture.

During the observation period, the individual's behavior and mental status are continuously monitored. This constant vigilance allows clinicians to track any fluctuations in symptoms, response to initial interventions, and overall progression of their mental state. The environment itself is designed to be therapeutic and safe, aiming to reduce agitation and promote stabilization. This might involve medication management, if clinically indicated and ethically permissible within the context of an involuntary hold, as well as de-escalation techniques and therapeutic communication. The objective is not necessarily to achieve full remission of symptoms but to gather sufficient evidence to determine whether the criteria for involuntary commitment continue to

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be met, or if the individual can be safely released or transitioned to voluntary care.

At the culmination of the observation period, a multidisciplinary team conference is typically held to consolidate all gathered information and make a final disposition decision. The options generally include: releasing the individual with recommendations for outpatient follow-up, initiating a longer involuntary commitment if criteria for continued detention are met (requiring further legal process), or facilitating a voluntary admission to an inpatient or residential treatment program if the individual agrees. This robust clinical protocol ensures that decisions regarding an individual's liberty and mental health care are made on the basis of comprehensive, evidence-informed psychiatric assessment within a legally defined framework.

8. Ethical Considerations

The practice of an observation hold, while designed for protection and care, is fraught with significant ethical considerations, primarily revolving around the delicate balance between individual autonomy and the principle of beneficence (acting in the best interest of the patient) and non-maleficence (doing no harm). The most prominent ethical dilemma stems from the **involuntary nature of the intervention**. Detaining an individual against their will, even for a short period and for their own safety, represents a profound infringement on their personal liberty and self-determination. Ethical frameworks typically emphasize the right of competent adults to make their own choices, even choices that might be deemed unwise by others. The justification for an observation hold therefore relies heavily on the premise that the individual's mental state has rendered them temporarily incompetent to make rational decisions about their own safety or the safety of others.

Concerns about **informed consent** are also central. While individuals under an observation hold are by definition unable or unwilling to consent to their detention, ethical practice dictates that they should be informed of their rights, the reasons for their hold, its duration, and the process for appealing it, to the extent that their mental state allows for comprehension. The challenge lies in communicating this information effectively to someone in acute distress, who may be experiencing psychosis, severe paranoia, or cognitive impairment. There is an ongoing ethical imperative to minimize coercion and to engage individuals in their treatment plan as much as possible, even when the initial detention is involuntary. This requires skilled communication and a patient-centered approach, even in restrictive environments.

The potential for **stigma and trauma** resulting from an involuntary hold is another serious ethical concern. Being subjected to a psychiatric hold can be a deeply disorienting and frightening experience, potentially leading to lasting psychological distress, mistrust of mental health services, and increased self-stigma. Ethical practice requires clinicians to minimize the potentially negative impacts of the hold, ensuring a dignified and respectful environment, clear explanations, and

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sensitive handling of the individual's emotional state. The lack of a welcoming, therapeutic environment, or insensitive interactions, can exacerbate existing trauma and undermine future engagement with mental healthcare, creating long-term detrimental effects despite the short-term protective intent.

Finally, the ethical allocation of resources plays a crucial role. Given the often-limited availability of psychiatric beds and specialized staff, ethical questions arise about who receives an observation hold and who might be turned away or held in less appropriate settings due to resource constraints. This raises issues of distributive justice and equitable access to emergency mental health care. Ethical guidelines demand that decisions regarding holds are made purely on clinical and safety criteria, free from bias related to socioeconomic status, insurance coverage, or perceived "deservingness." The ongoing ethical challenge is to refine policies and increase resources to ensure that the observation hold serves its intended purpose as a protective and therapeutic intervention, minimizing its coercive aspects and maximizing its potential for positive impact on individuals' mental well-being while upholding their fundamental human rights.

9. Interdisciplinary Collaboration

Effective implementation of an observation hold relies heavily on robust and seamless **interdisciplinary collaboration**, bridging the traditionally distinct domains of law enforcement, emergency medical services, and mental health care. This collaborative model is fundamental because an individual requiring an observation hold typically enters the system through an initial crisis response, often involving police officers or paramedics, before transitioning to a specialized clinical setting. The success of the entire process, from initial contact to final disposition, is predicated on clear communication, shared understanding of roles, and mutual respect among these diverse professional groups.

Law enforcement officers frequently serve as the **first responders** to situations involving individuals in acute mental health distress, particularly when there are concerns about public safety or self-harm. Their role often involves de-escalating volatile situations, ensuring the safety of all parties, and making the initial determination that a mental health crisis, rather than solely criminal activity, is at play. Proper training for officers in crisis intervention techniques and mental health first aid is crucial to ensure that individuals are handled sensitively and appropriately, facilitating a safe transport to a medical facility rather than immediate arrest. This initial collaboration sets the tone for the individual's entry into the mental health system, greatly influencing their experience and willingness to engage.

Upon arrival at a medical facility, the baton passes to **emergency medical and psychiatric teams**. Emergency room physicians and nurses are responsible for the initial medical screening, ruling out physical causes for behavioral changes, and stabilizing any acute medical issues.

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Concurrently, or subsequently, mental health professionals--including psychiatrists, psychologists, social workers, and specialized nurses--take the lead in the comprehensive psychiatric assessment. Their collaboration involves sharing information received from law enforcement, conducting detailed clinical evaluations, and collectively determining the appropriate course of action based on clinical findings and legal criteria. This continuous flow of information and shared decision-making ensures that the individual's needs are addressed holistically, considering both their physical and mental well-being.

Moreover, effective collaboration extends beyond the initial hold to the **disposition and follow-up care**. Social workers often play a pivotal role in coordinating discharge plans, connecting individuals with community mental health resources, housing, and social support services. This requires collaboration with outpatient mental health providers, case managers, and family members. Challenges often arise from disjointed systems, communication breakdowns, or a lack of resources in one sector, which can undermine the efforts of others. Therefore, developing integrated crisis response teams, co-responder models (where mental health professionals accompany police), and streamlined referral pathways are ongoing efforts aimed at enhancing this crucial interdisciplinary collaboration, ensuring that the observation hold functions not as an isolated event but as a well-integrated component of a broader system of care.

10. Future Directions and Challenges

The future trajectory of observation holds will likely be shaped by ongoing efforts to refine legal frameworks, improve clinical practices, and address persistent challenges in resource allocation and ethical considerations. One significant direction involves enhancing the **integration of mental health services within crisis response**. This includes expanding the deployment of co-responder models, where mental health professionals accompany law enforcement on calls involving behavioral crises. Such models aim to reduce reliance on police as primary mental health responders, potentially leading to fewer arrests, more appropriate diversions to mental health care, and a decrease in the initiation of observation holds when less restrictive alternatives are viable. The goal is to ensure that the initial response is clinically informed, de-escalatory, and oriented towards support rather than enforcement.

Another critical area for future development lies in **leveraging technology and data analytics** to improve the effectiveness and fairness of observation holds. This could involve developing more standardized assessment tools, utilizing predictive analytics to identify individuals at high risk for mental health crises who might benefit from pre-emptive interventions, and tracking outcomes to evaluate the efficacy of observation holds and subsequent care. Data can also be instrumental in identifying potential disparities in the application of holds across different demographic groups, thereby informing policy changes aimed at promoting equity and reducing bias. However, the ethical implications of data privacy and algorithmic bias must be carefully navigated as these

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technologies are integrated.

Addressing the persistent challenge of **resource scarcity** will also be paramount. The effectiveness of observation holds is often constrained by a lack of available psychiatric beds, insufficient outpatient mental health services, and inadequate funding for crisis intervention programs. Future efforts must focus on increasing investment in mental health infrastructure, including more crisis stabilization units, walk-in clinics, and community-based support services that can serve as alternatives or follow-up pathways to observation holds. This expansion of resources is vital to ensure that individuals receive not only appropriate assessment but also sustained care, preventing a revolving door phenomenon where individuals repeatedly cycle through emergency holds due to a lack of long-term support.

Finally, ongoing dialogues about **ethical oversight and patient advocacy** will continue to shape the future of observation holds. There is a continuous need to review and update legal criteria, enhance due process protections, and strengthen mechanisms for patient advocacy to safeguard individual rights. Promoting patient-centered care, even within involuntary settings, by involving individuals in their treatment planning as much as possible and providing clear, empathetic communication, will be crucial. The ultimate goal is to evolve the observation hold into an intervention that is not only legally sound and clinically effective but also deeply respectful of human dignity, serving as a beacon of compassionate care for those in their most vulnerable moments.

Further Reading

Involuntary commitment - Wikipedia
Mental health crisis - Wikipedia
Due process - Wikipedia
Deinstitutionalization - Wikipedia
California Welfare and Institutions Code Section 5150

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