



The Unit

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This is the second essay in what is apparently becoming a series. In [Mental Health \(for Humans\)](#) I presented my credentials: sick as fuck, disabled in fact, ten-plus years inside the system. That essay argued that the system's core abstractions are delivered backwards, that a diagnosis is a lookup key and not a life sentence. This one walks into the most mythologized room in the building and turns the lights on.

The psychiatric unit. The ward. The floor. The place everyone is terrified of and almost nobody writes about, because the people who've been inside mostly want to forget it, and the people who haven't get their information from *One Flew Over the Cuckoo's Nest*.

I have been hospitalized more times than I can count on one hand. I generally go to Behavioral Health Services at Valley Health Winchester Medical Center, which is a strange sentence to be able to write: I have a usual. Like a coffee order. I know the intake routine, the vinyl smell, the specific weight of the chairs. I've also been to other facilities, which is how I know that my usual is one of the better ones, and how I learned the lesson this essay is really about. But we'll get there.

Nobody writes the practical essay about psychiatric hospitalization. There are despair memoirs and recovery-arc memoirs, and both genres treat the unit as a dramatic setting rather than what it actually is: a tool, with a specific function, that you might one day need to use. So here is the essay I wish someone had handed me before my first admission. Documentation, not memoir.

What the Unit Actually Is

Strip away the mythology and a psychiatric unit is this: a locked floor where the stimulation is reduced to nearly zero, your medications can be changed quickly under observation, and you cannot hurt yourself while the new chemistry loads.

That's it. That is the whole machine.

```
def psychiatric_unit(patient):
    """Not a fix. A halt."""

    process.pause(patient)           # containment
    state = observe(patient, days=7) # assessment
    patient.medication = adjust(state) # the lever
    patient.sleep = enforce()        # the actual medicine

    return patient # still sick. no longer in freefall.
```

The unit is a debugger with bad lighting. It halts the running process so the state can be inspected and the configuration changed. It is not where healing happens; healing happens afterward, slowly, at home, in [the long unglamorous work of maintenance](#). The unit exists for the moment when the process is in freefall and no change you make from inside a crashing system will land.

Knowing this matters, because both of the popular myths get it wrong, and both myths hurt people. The dungeon myth keeps people out who desperately need the halt; they white-knuckle a psychotic break at home because they think the ward is where your personhood goes to die. The cure myth sends people in expecting to come out fixed, and they come out medicated, exhausted, and still sick, and conclude that treatment failed. It didn't fail. It did the only thing it does. The unit is a reboot, not a repair. The repair is outpatient, and it takes years.

The boredom, by the way, is load-bearing. Everyone who has been inside complains about it: the dayroom, the TV with the channel nobody chose, the schedule of groups, the absolute crawl of the afternoon. That boredom is the clinical intervention. A mind in mania or psychosis is being fed by everything; the unit is an environment engineered to feed it nothing.

Once you understand the design constraints, everything strange about the unit explains itself. The furniture is too heavy to lift. There are no drawstrings, no shoelaces, no spiral notebooks. The mirrors are polished steel. The whole room has been adversarially red-teamed against a person at their worst moment. It is the most honest "designing for the worst day" environment in existence, and I say that as someone who writes about [designing for the worst day](#).

The Front Door Is the Worst Part

Here is something I didn't understand until I'd been through it from multiple directions: how you arrive shapes everything, and the arrival is the most inhumane part of the entire system.

My first time, in 2016, I walked in for what was called a "[Voluntary Psychological Evaluation](#)". I was under the impression that voluntary meant I could leave. It did not. Voluntary meant I had walked in under my own power; whether I walked out was now a clinical decision. Nobody explained this to me beforehand, and I want to explain it to you now, while you're well: **learn what "voluntary" means in your state before you ever need to know.**

The rules vary by state. In Virginia, the involuntary path runs through a magistrate: a sworn petition, a temporary detention order, a hearing within days. Other states differ in their thresholds and timelines. None of this is secret; all of it is unknown to almost everyone until the night it happens to them.

And when I'm too far gone to walk in at all, it gets worse. Sarah has [written about what this actually requires of her](#): when I'm manic past the point of self-awareness, I don't want to go. Everything is vivid and fast and fun, and the rational instrument that would agree to admission isn't driving anymore. So she has to go to the magistrate, write out a sworn statement at the local jail describing how the person she loves has become a danger to himself, and petition the court. If the magistrate accepts it, the police come, and I am escorted to the hospital in handcuffs. I have never been violent and never resisted. The handcuffs are policy.

Sit with that design for a moment. The front door of mental health care, for a person in the most acute phase of a medical condition, is a courtroom and a squad car. We do not send police to collect people having heart attacks. The commute to care is, reliably, the most traumatizing part of the care, and it is traumatizing for the family member who initiated it in a way that never fully heals. Whatever a psychiatric system for humans looks like, it does not look like that.

The Discharge Performance

Now for the part of this essay I most need you to understand, because nobody inside the system will say it to you plainly.

You do not get discharged from a psychiatric unit because a measurement says you're well. There is no lab value for stability. You get discharged because you present as well: groomed, calm, sleeping through the night, attending groups, speaking in measured sentences about your safety plan and your follow-up appointments. Discharge is an audition. Every patient figures this out within about two days, and the dayroom quietly coaches newcomers on the script.

```
def ready_for_discharge(patient):
    # What the system can measure
    return (
        patient.groomed
        and patient.attends_groups
        and patient.speaks_calmly
        and patient.demonstrates("insight")
    )
    # What the system is trying to measure
    # has no function signature
```

This is the same disease I keep finding everywhere: the legible metric standing in for the meaningful one.

Goodhart's law: when a measure becomes a target, it ceases to be a good measure. The discharge meeting is Goodhart's law with a clipboard. The patients optimizing hardest for the presentation of wellness are not reliably the wellest patients. Sometimes they are the most practiced.

Wellness is hard to measure, so the unit measures presentation, and presentation becomes the target, and patients learn to perform it whether or not the wellness underneath exists. The performance has a clinical name, even: "insight." You demonstrate insight by agreeing with your treatment team about what is wrong with you. Notice the trap. Agreement is health; disagreement is a symptom. There is no move inside that game that registers as honest dissent.

I'm not claiming insight is fake; anosognosia is real, and I've had it. When I'm manic I sincerely believe I'm fine, and [Sarah's outside view](#) is better data than my inside one. The problem isn't that the system weights insight. It's that the system cannot distinguish insight from a well-rehearsed imitation of it, and the imitation is taught, free of charge, in every dayroom in America.

And here is the moment the whole inversion became unmissable for me. At one facility I stayed in, The Pavilion, the shower in my room didn't work. Not "low pressure." Didn't work. And the discharge criteria, the audition rubric, included presenting as clean and tidy, because grooming is scored as a sign of returning health.

Read those two sentences together. The institution could not provide working plumbing, and the institution graded my recovery on my grooming. I was being evaluated on an output while being denied the input. That is the entire pathology of the system, compressed into one room: it measures the performance of wellness while failing to supply the conditions of wellness, and when the performance falters, the failure is recorded as yours.

I want to be fair, because fairness is the point of this series: my usual unit, BHS at Winchester, is genuinely better than that. The care is more humane, the staff more present, the machine better maintained. Which is exactly what makes the comparison damning. The difference between a unit that helps you and a unit that warehouses you is enormous, invisible from the outside, and completely outside your control at the moment of admission, because in a crisis you go where there is a bed. The same lottery that [hands you School A or School B on your medication](#) hands you a working shower or a broken one, and grades you identically either way.

How to Use the Unit

The unit is a tool. Here is what a decade of admissions has taught me about using it well, written for the person who may someday need it:

- **Go earlier than you want to.** The single biggest improvement in my outcomes came from shortening the distance between "Sarah sees it" and "I go." Going early means going voluntarily, which means no magistrate, no handcuffs, more agency inside, and a shorter stay. Every hour of resistance makes the eventual arrival worse.
- **The fastest way out is through.** I solved this puzzle [the hard way in 2016](#): the simplest way to leave the hospital was to take the medicine they'd been offering and get some sleep. Work the program for real. Sleep when they tell you. Take the meds. Go to the groups. The treatment and the audition mostly overlap, and where they overlap, honesty is also the optimal strategy.
- **Know the rules before the crisis.** What "voluntary" means in your state. What the involuntary process is. What your rights are on the inside. You cannot learn the rules of a game while psychotic. Learn them now, write them down, tell your people where the document lives.
- **Pack for it in advance.** Comfortable clothes with no strings. A few phone numbers on paper, because your phone is going in a locker. A book. Keep the list somewhere your support person can find it, because you may not be the one packing.
- **Your people are your continuity.** Inside, your sense of time and self gets soft. The person who visits, who answers the unit phone, who holds the thread of your actual life, is doing clinical work even though no one will call it that. Sarah has carried that thread through every admission I've had. It is half the reason I keep coming home.
- **Treat discharge as a beginning.** The unit halted the freefall. The treatment is the outpatient follow-up, the medication tuning, the [partnership with providers you trust](#). People who treat discharge as the finish line reliably end up readmitted. I know because I used to be one of them, roughly annually, [for years](#).

The Bar Is a Working Shower

What would a psychiatric unit for humans look like? After everything I've seen, my honest answer is embarrassingly modest.

It would have working showers, because dignity is not an amenity in a place that grades you on grooming; it is clinical infrastructure. It would have a front door that doesn't involve handcuffs for compliant patients. It would tell you what "voluntary" means before you sign. It would score discharge on function and support, not on how convincingly you perform serenity in a fifteen-minute meeting. It would treat the patient as [a partner with privileged data](#) rather than a process to be managed to a presentable state.

None of that is utopian. Most of it is plumbing, paperwork, and respect. The bar is so low it is lying on the floor of a room with a broken shower, and still, half the system trips over it.

I said the last essay was argued from the waiting room. This one is argued from further inside, from the dayroom, from the vinyl chair, from the wrong side of the locked door. I know the unit as well as I know any room in my life, and this winter, for the first time in years, [I didn't see it at all](#).

That's the strange thing about writing documentation for a tool you hope to never use again. I have a usual. I'm working, every day, on never needing it.

But if you ever need yours: go early, sleep, take the medicine, work the program honestly, and remember that the audition is not your life. The unit is a halt, not a verdict.

Walk in knowing that, and you've already beaten the room.