

Exploring the Legal Consciousness and Mobilization of the Mental Illness Suffers

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Undergraduate Honors Thesis in Legal Studies

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Acknowledgements:

Special thanks to my advisor Jonathan Simon for all the guidance he has given me throughout the semester. I would also like to thank Professor Michael Musheno, Jamie Rowen, and Lauri La Point for their guidance and support on my thesis. Thanks also to Daniel Bessonov, the Understanding Depression facilitator, for helping me establish contacts for my research. Lastly, I thank all the participants who courageously shared their stories with me.

Table of Contents

I. Abstract (p.4)

II. Introduction (p. 5)

III. Literature Review (p. 6)

IV. Methodology (p. 19)

V. Findings (p. 28)

VI. Conclusions and Reforms (p. 59)

VII. Works Cited (p. 62)

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I. ABSTRACT

This research investigates how law matters in the experiences of mental health patients who have experienced hospitalization due to their mental illness. Through semi-structured interviews and narrative analysis, it attempts to uncover, from the perspectives of mental health patients themselves, how mental health patients understand and mobilize the law. This research attempts to answer the following: 1) How do mental health patients understand their rights in mental hospitals? 2 a) In what ways do mental health patients encounter the law in hospitals? 2 b) In what ways are their hospital experiences shaped by law? 3) What does the legal mobilization process look like for mental health patients?

Socio-legal research findings reveal that few rights violations make it to formal adjudication (about 5%). It is expected, however, that this number will be even lower for mental health patients due to the discouraging power relationships between physicians and patients and the ambiguous boundaries between what constitutes inappropriate or unnecessary treatment for mental health patients. This research aspires to spell out some of these ambiguities in the intersection between mental illness and law that may prevent mental health patients from mobilizing the law. It, moreover, aims to add to the socio-legal literature on legal mobilization by studying how law is mobilized in this specific population. While extensive theoretical debates and literature on patients rights of the mentally ill has been written from scholarly perspectives, this research aims to investigate how these patients rights actually matter on the ground for mental health patients. In other words, rather than testing scholarly theories about law and

patients rights, it seeks to generate new theories and/or meanings about law and patients rights from the unique perspective of mental health patients.

II. INTRODUCTION

Part of socio-legal scholarship investigates how law matters in the lives of everyday people. It acknowledges that law extends much further than law on books; in fact, law is a social institution that interacts with many facets of social life. Socio-legal research, furthermore, explores how people understand and exercise the law; how people's lives are shaped by the law itself; and how people mobilize the law.

Likewise, an extensive amount of literature exists investigating the intersection between law and mental health. Much of these literatures are theoretical and written from legal, medical, and psychological perspectives. They attempt to reconcile the somewhat incompatible nature between law (which is precise, written, and certain) and mental health (which is ambiguous, uncertain, and often poorly understood). Many of the hot button issues regarding law and mental health involve assessing competency to refuse treatment and involuntary hospitalization of the mentally ill (Grisso 1998, Victoroff 1969). Despite ample literature on these topics, much of the works written are theoretical, rather than empirical. Even more so, they are the theoretical, normative claims made by scholars and physicians --very little is said, if at all, from the perspective of mental health patients on these issues.

This research is partly an attempt to bridge the gap between socio-legal research and the theoretical literature on law and mental health. It explores how mental health patients perceive, understand, and mobilize law in the context of hospitalization. It further examines how law may shape the hospitalization experience of the mentally ill, and the meanings that mental health patients give to. Furthermore, it investigates how perceptions of procedural justice and the normative concept of dignity matters in the experiences of mental health patients. Lastly, through

story-based interviews and narrative analysis, it attempts to give mental health patients a voice, and explore the issues surrounding mental health and law from their unique perspectives.

Research Questions:

- 1) How do mental health patients understand their rights in mental hospitals?
- 2) In what ways do mental health patients encounter the law in hospitals? And in what ways are their hospital experiences shaped by law?
- 3) How do mental health patients mobilize the law in hospital settings?

III. LITERATURE REVIEW

Socio-legal literature on legal mobilization and legal consciousness grounds my research and guides my inquiry. Literature on mental health (both from legal and medical fields) help me to gain insight into what factors may contribute to mental health patients understandings of the law and also help me to conceptualize what their legal mobilization process may look like. The concepts and models of legal of legal consciousness and legal mobilization (e.g. the dispute pyramid) will help me to categorize my findings. It also guides me to be aware of the various patterns that may be present in how mental health patients mobilize the law. Review of the literature on procedural justice and dignity, moreover, help me to better contextualize and understand my findings.

A. LEGAL CONSCIOUSNESS

1. Defining and Conceptualizing Legal Consciousness - Ewick and Silby

One of the fundamental tenets of socio-legal legal scholarships is that law extends far outside the boundaries of formal courts. In *The Commonplace of Law*, Patricia Ewick and Susan S. Silby investigate law and legality in everyday lives of Americans, and their findings reveal that Americans' heads are filled with ideas about law. They find that law influences the way in which we think about social categories and fairness. But where did these ideas come from? In

other words, how is legal consciousness created in our minds? Ewick and Silby conceptualize this phenomena as “legal consciousness.” I borrow Ewick and Silby’s definition and concept of legal consciousness as I investigate the meanings of law and legality for mental health patients.

Legal consciousness is a difficult to define and conceptualize because it is both lucid and elusive (Ewick and Silby 1998: 27). At times, there is an absence of legal consciousness, and at other times, law and legality is characterized more explicitly (Ewick & Silby 1998: 15). In general, legal consciousness refers to the way in which people understand and make use of the law, as well as how law constructs or gives meaning to their social life.

One way is to conceptualize legal consciousness is to see it on a spectrum. On the far left of the spectrum is the attitudinal model of legal consciousness (Ewick & Silby 1998: 35). On the far right of the spectrum is the structural model (“Legal Consciousness as Epiphenomenon”) (Ewick & Silby 1998: 36). The attitudinal model of legal consciousness argues that individual attitudes, desires, and beliefs, and capacity shape legal consciousness. Thus, legal consciousness is individually determined and idiosyncratic; it is reflective of his or her experiences (Ewick & Silby: 36). On the other hand, the structural model, rooted in structural anthropology and Marxist structuralism, contends that legal consciousness is a product of social structure; structure, not individuals, produce ideas about law. Legal consciousness as, as Ewick and Silby define it, falls somewhere in the middle of the spectrum. In a paradoxical way, individuals are constrained by the social context, but they also have agency within that context (Ewick & Silby 1998: 38). It’s almost like improv theater, where the actors are asked to improvise a sketch while being given limited time, props, and topic. In my research, I examine how experiences with mental illness and hospitalization affect the legal consciousness of patients.

2. Legal Consciousness: Identity and the Law

Engel and Munger expand on this concept of legal consciousness in their study of ADA (American Disabilities Act) and its impact on disabled persons. They identify an ongoing and

recursive relationship between identity and the law (Engel & Munger 2003: 241). For one, ADA rights, changed the self-perceptions of some individuals with disabilities. New rights allowed these individuals to consider and pursue more ambitious career paths. Second, ADA rights changed the way Americans talked about disabilities in everyday life. Drawing parallels from Engel and Munger's research, I examine recursive relationship between mental health identity and the law. How does patient's rights shape the identity of mental health patients? And how does the identity of mental illness shape law and the way the law is mobilized? Moreover, Engel and Munger's research investigates how the changing legal definition of "disability" impacted the lives of the disabled. In my research, I probe for how legal definitions of the mental illness influences the identity of the sufferers, and consequently impact how sufferers perceive and mobilize the law.

B. LEGAL MOBILIZATION

1. Concept and Model:

The concept of legal mobilization "refers to the social processes through which individuals define problems as potential rights violations and decide to take action within and/or outside the legal system to seek redress for those violations" (Morrill et. al 2010). It relies on the notion that not all laws are self-executing. Unlike traffic laws that instruct everyone to drive on one side of the street, laws such as discrimination laws rely on individuals recognizing grievances and demanding his or her rights in some manner. In Morrill et.al's study of legal mobilization in schools, identify four actions of how the law is mobilized once a rights violation has been perceived:

- (1) Formal legal action, such as filing a formal lawsuit, filing a formal complaint with a government agency (e.g. the Equal Employment Opportunity Commission), or contacting a lawyer;
- (2) quasi-legal action, such as using formal complaint procedures (e.g. an archdiocese), or using some sort of internal dispute resolution forum (i.e.,

mediation, peer counseling, etc.); (3) extralegal action, such as contacting the media, directly confronting the person verbally or physically, seeking support from a counselor or religious professional, avoiding the person, talking with peers or family members, or engaging in prayer; and (4) doing nothing (“lumping it”). (Morril et.al 2010)

Individuals usually can pursue strategies (1-3) in concert with one another, which may be both mutually reinforcing or contradictory to one another. They may also gravitate between more formal and less formal strategies in non-linear ways (Morril et. al). These four actions can be mapped on to a dispute pyramid -- a graphic description of the legal mobilization process. At the very base of the pyramid are perceived rights violations. The tip of the pyramid represents formal legal action (which constitutes about 5%). Other strategies such as doing nothing, extralegal, and quasi-legal fall in between the base and the tip of the pyramid, respectively.

The four actions of legal mobilization and the dispute pyramid provide a framework that can be used to theorize the legal mobilization process of mentally ill patients. There has been various literature studying legal mobilization in various populations (youth, racial/ethnic minorities, and women) and institutions (workplace and schools). But I have not come across any literature that investigates legal mobilization with respect to mentally patients and hospitals. Neal Milner’s “The Dilemmas of Legal Mobilization: Ideologies and Strategies of Mental Patients Liberation Groups” comes close; however, Milner’s focus is on Mental Health Liberation groups (a political group) -- not mental health patients themselves. This research explores and builds on the concept of legal mobilization as it applies to mental health patients in the hospital setting.

2. Transformation of Disputes and Legal Mobilization

Felstiner, Able, and Sarat’s research, titled “The Emergence and Transformation of Disputes: Naming, Blaming, and Claiming” demonstrates that that the base of this dispute pyramid should be widened to include unperceived rights violations.

Felstiner et.al's research demonstrates that disputes can be understood as social constructs that are defined and transformed by social forces and the legal system. How we define -- or name -- something as an injurious experience is influenced by social, cultural, and legal norms (Felstiner et. al 1981: 631) For example, how should we view a woman leaving her job after pregnancy? In the past, this was typically viewed as a life transition. But could it also be an example of gender and employment discrimination? Moreover, a shipyard worker may not be aware of the fact that he is inhaling asbestos in his workplace, and hence cannot "name" his experience as injurious.

After an experience has been perceived (or named), in order for the experience to transform into a dispute there must be another party who is blameworthy(Felstiner et.al 1981: 653). After all, bad, injurious experiences occur all the time in life. Your friend's dog gets run over by a car. You spill hot coffee on your lap, resulting in a first degree burn. Both examples are injurious experiences, but you may see your friend's dog getting over by a car as an accident rather than blaming it on the driver. You may blame yourself for spilling coffee on your lap rather than Starbucks employee who did not warn you of how hot the coffee will be.

After "naming" and "claiming", you must claim your experience, meaning that you confront the blameworthy person and ask for a remedy. If your request for a remedy is rejected, it becomes a dispute (Felstiner et.al 1981: 653). However, for various reasons, you may not choose to "claim." Perhaps the driver who ran over your friend's dog is a good neighbor of yours, and you don't want to "stir up" drama in the neighborhood. Power also influences moving from "blaming" to "claiming." You may be less likely to "claim" if you are scared, hopeless, or worried about retaliation (perhaps the neighborhood bully ran over your friend's dog). Moreover, remedies may seem unlikely, costly, or inadequate. After considering how much time and money it would cost to sue the Starbucks employee, you may think it's not worth it and do nothing ("lump it").

The “naming,” “blaming,” and “claiming” model has several important implications for the research that I will be pursuing. I’m interested to find out what the “naming” stage (going from unperceived injurious experience to perceived injurious experience) looks like for mental health patients. What happens when certain injurious experiences look ambiguous in the perspectives of mental health patients? If a doctor confines a mental health patient to his or her bed, is that an act of control, or is it an act of care? What are mental health patients’ perceptions of what constitutes as acts of help or acts of injury, and how does it influence their legal mobilization process?

Similar questions also arise in the “blaming” and “claiming” stage. Who do mental health patients blame once they perceive an injurious experience? Perhaps a mental health patient with low-self worth would blame themselves more than others. It’s also possible that mental health patients might blame their family members or friends. Lastly, does the unequal power relationship between physician and patient impact “claiming”? If a patient is battling a serious mental illness, perhaps he or she does not want to take on the extra burden of bringing a legal challenge and decide to “lump it.”

C. BARRIERS TO LEGAL MOBILIZATION

1.Traditional Barriers to Legal Mobilization in Socio-Legal Literature

There are both structural and social/psychological barriers to legal mobilization. Some obvious examples of structural barriers to legal mobilization may include the legal costs and the time needed to pursue a claim.

Moreover, Bumiller’s studies on Civil Rights (1964) mobilization among populations who decided to “lump ” (do nothing) their perceived rights violations revealed that they did so based on various psycho-social reasons (Bumiller 1986: 421). One reason is that power among social relations prevented people from mobilizing their rights any further. They were fearful of

loss and retaliation. Another factor that contributed to suppression of legal mobilization was the way in which anti-discrimination law defined discrimination. The law's definition gave the idea that those who mobilized their Civil Rights were "victims." Many were discouraged to mobilize because they did not want to take on the negative image of the vulnerable victim in need of protection. The definition of the law thus had ironic consequences because the very law that was constructed to remedy discrimination simultaneously kept people from mobilizing. (Bumiller 1986: 438).

Mental health patients may encounter some of these barriers as part of their legal mobilization process. Structural barriers such as money and time will certainly influence the ways in which some mental health patients mobilize their rights. The social/psychological barriers regarding power in social relations is also relevant to how mental health patients mobilize their rights in the hospital, due to the unequal power relations between physician and patient (discussed in further detail later). Bumiller's research also informs me that legal definitions and wordings of mental health and rights are important considerations for legal mobilization. This research inquires for the mental health patients' perspectives on law and patients rights.

2. Competency as Barrier to Legal Mobilization

Civil commitment standards (LPS Act) in California do not include a competency assessment, nor are mental health sufferers presumed to be incompetent once they are involuntarily committed (Welfare and Institutions Code Sec 5326.5 and 5331) . However, discourses about competency from legal, medical, and psychiatric perspectives continue to plague mental health sufferers dialogue regarding receiving treatment and hospitalization. Competency, moreover, is problematic because any standard of competency requires some sort of normative assessment (Saks 2002: 175). I mention competency in my literature review, not only because it is a dominant discourse among scholars and physicians, but among the mental

health population themselves. From my experience in the Depression DeCal, guest speakers (mental health patients) frequently questioned their own competency when it came to “doing something” about incidents of humiliation or mistreatment. I anticipate this discourse to appear in my interviews. Even more so, I believe that this competency discourse will be a barrier to legal mobilization, as anyone who doubts his or her own competency is likely to also doubt his or her capability in mobilizing the law. Thus, when I mention competency in my findings, I refer to what my interview subjects have defined and discussed as competency (a person’s mental and educational abilities) rather than the legal definition.

3. Psychiatric Power as a Barrier

The naming, blaming, and claiming process of legal mobilization as well as Bumiller’s study on social/psychological barriers to legal mobilization already reveal how power affects legal mobilization. It’s significant to discuss how psychiatric power may further pose as a potential barrier for legal mobilization.

Thomas Szasz describes the relationship between the institutional psychiatrist and his involuntary patient as akin to master and slave more than physician and adult medical patient (Szasz 1974: x) Moreover, even the notion of the doctor as a health care provider hints at the underlying dynamics of unequal power; paternalism suggests that the skilled and knowledgeable care provider (the powerful) will help the sick, weak, and vulnerable patient (the powerless). Thus, in Szasz’s view, the institution of psychiatry is all about obtaining and maintaining power -- not treatment. Like prisons, mental hospitals serve the purpose of controlling those deemed socially deviant (Szasz 1974: iv) And like slavery, mental hospitals are “complex social-economic phenomenon[on] of longstanding and practical importance” (Szasz 1974: x). As Western society moved away from Age of Faith that persecuted heretics under the power of church, modern society persecutes the mentally ill under the power of the state and science (Szasz 1974:

360). Hence, starting with the transition of Age of Faith to the Age of Reason, Szasz describes the birth, the growth, the flowering, and the abuse of psychiatric power in the context of involuntary and forced hospitalization.

Szasz's take on psychiatric power, however, relies on the assumption that all mental illnesses are myths created to legitimize the control of the socially deviant (Szasz is also author of the book *The Myth of Mental Illness* 1974). Of course, Szasz's literature is dated, as new brain research suggests biological bases for mental illness. Hence, the question of whether mental illness exists is much less debated today, than it was during the 1970s (Saks 2002: 20).

Nevertheless, Szasz's literature should not be wholly discounted. It is a widely known social fact that homosexuality has long been considered a mental illness until it was removed from the Diagnostic Statistical Manual in 1986. Hence, while the tendency is to think of science and medicine as objective and face neutral, historical evidence reveals science and medicine being used as way to control those deemed socially deviant (Szasz 2002: 360). Saks, moreover, also notes the difficult in distinguishing deviance from actual mental illness (Saks 2002: 21). For example, should hearing voices from God be categorized as a symptom of mental illness or a religious, spiritual experience?

Perhaps one of the most important tenants to understand about Szasz's conception of psychiatric power is its ambiguous nature. Sak's also hints at this ambiguous nature when she discusses how difficult it is to distinguish which actions of the psychiatrists can be conceived as genuine care for the mentally ill, and which should be conceived as breaches on the mentally ill's liberty and autonomy (Saks 2002: 6-7). And according to Szaz, "... if the protectors are successful, they inevitably become oppressors ..." (Szasz 1974: 360). Hence, how much psychiatric power should be justified on the bases of caring for the ill? Both Szaz and Saks helps me to gain greater insight into how power may operate between physicians and patients, and

therefore, insight into how the unequal power relationships may shape the legal consciousness and mobilization process.

4. More on Psychiatric Power: Physicians as Repeat Players

From the perspective of legal scholarship, law is seen as resolving all struggles of power. In court, theoretically, reason prevails and power can be set aside. Socio-legal scholarship, however, contends the opposite perspective. Power does play a significant role in courts. The “haves” tend to win over the “have-nots.”

Marc Galanter’s socio-legal research reveals how the legal system is set up to privilege those with more resources and power. He identifies two types of parties in the legal system: one-shot players and repeat players. One shot players, encounter the legal system occasionally and unpredictably, and generally expect the legal encounter to not happen again. Repeat players, however, engage in repeated litigation and have the resources to do so. They also see individual suits as small parts of ongoing stream of litigation and tend to use the repeat nature of litigation to pursue long-run interests. Galanter identifies several examples of how the legal system advantages repeat players: (1) repeat players have advanced knowledge of the legal system; (2) they are less likely to be intimidated by going to court due to their greater familiarity of the legal system; (3) they have low-start up costs because they hire lawyers on an ongoing basis who are familiar with repeat player’s operations; (4) they are better able to withstand legal delays due to their long-term strategy and resources; and (5) they are able to shape the law in terms of their interest by lobbying for their interests, strategically picking cases that set precedent, and allowing one-shot players symbolic victories (Galanter 1974: 160).

In understanding the influence of psychiatric power’s influence on legal mobilization, it is important to recognize physicians as repeat players; therefore, they are in a much more advantaged position when it comes to disputes with their patients. The characteristic of the

physician as a repeat player may also be another barrier for legal mobilization of mental health patients.

Furthermore, Carol Heimer, in “Competing Institutions: Law, Medicine, and Family in Neonatal Intensive Care” observes that laws that become influential in the NICU are laws that benefit high status professionals (mostly physicians), due to the fact that physicians, as repeat players, are more easily able to incorporate laws into the NICU units. Hence, the repeat players come to shape how law operates in the NICU setting (Heimer 1999: 17). Heimer’s research gives important insights into how law on the books differs from law in action. Though laws that benefit one-shot players may be written, they come to only have symbolic importance if they are not incorporated into the institutional setting. My research similarly examines, through the perspective of mental health patients, how law operates on the ground.

D. PROCEDURAL JUSTICE AND DIGNITY

1. Procedural Justice

Procedural justice, simply put, refers to the fairness of the process, and is contrasted with substantive/distributive justice, which refers to the fairness of the outcome. Tyler and Lind’s study on procedural justice found that perceptions of procedural justices mattered greatly when it came to disputant satisfaction, perceptions of legitimacy, and obedience to the law. Tyler and Lind describe various factors influence perceptions of procedural justice for participants in the legal system; they include: substantive outcomes, degree of party control over the process, ability of parties to express their positions, and “ethicality” or whether the decision maker was respectful and polite (Tyler and Lind 1988: 93).

In a 1984 study, Tyler surveyed defendants in traffic and misdemeanor courts concerning “their satisfaction with their case, their evaluation of their judge, and their evaluations of the court system.” A variety of questions were devised to probe for procedural and distributive

fairness of the respondent's court experience and likely outcome. The findings of the study revealed that, though both procedural and distributive justice were important, procedural justice was more important than distributive justice in assessing attitudes towards the court. Furthermore, Tyler found that higher levels of perceived procedural justice led to more favorable evaluations of legal institutions and authorities (Tyler and Lind 1988: 66).

Following the description of Tyler's study, Tyler and Lind discuss the important policy implications of procedural justice. For one, they argue that procedural justice can serve as a "cushion of support," protecting institutions from hostility stemming from unpopular decisions (Tyler and Lind 1988: 64). In other words, when people perceive the process to be fair, they are more likely to accept negative outcomes. Moreover, as Tyler and Lind points out, because many citizens contacts with legal institutions are involuntary or involve some imposition of involuntary decisions and rulings, procedural justice plays an important role in promoting citizen's satisfaction with their legal experience and their perceptions of legitimacy of law and legal authority (Tyler and Lind 1988: 64).

Lastly, Tyler's research identified a link between procedural justice and compliance with the law. In general, people are more likely to accept and comply with decisions they view as fair. Therefore, Tyler and Lind argues that the more people perceive they were treated fairly during the process, the more likely they will accept and comply with the court's decisions (Tyler and Lind 1988: 81). In this research, I explore and identify how perceptions of procedural justice mattered for mental health patients in hospital setting.

2. Dignity

In the 20th century, civil commitment laws permitted involuntary hospitalization based on the diagnosis of mental illness. As a result, tens and thousands of adults were involuntarily hospitalized for years without receiving proper treatment (Palley et. al 2012: 91). The LPS reforms sought to end the warehousing effect by setting timelines for involuntary hospitalization.

Under the LPS Act, a person who is identified as a danger to self, danger to others, or gravely disabled can be involuntarily hospitalized for 72 hours (California Welfare & Institutions Code 5150). Longer detention of an individual, after the 3 day hold, elicits further review by professionals.

Recently, however, reformers and advocates of mental health argue that the LPS Act is too limiting, and that it does not provide adequate treatment for the small segment of mental health sufferers who are at risk of falling more deeply into their illness, homelessness, or incarceration. Reformers and advocates, thus, call for a more robust form of treatment (Palley et al 2012: 4). Meanwhile, the California prison system is suffering from mass prison populations (mass incarcerations). With shrinking numbers of mental hospitals, increasing amount of people in prisons are suffering from mental illnesses. In attempts to balance California's increasing prison population and the shortage of care for mental health sufferers, Palley et. al in, *Dignifying Madness*, recommends a dignity-centered reform that would "place dignity at the very center of a new legal architecture for governing madness" (Palley et al. 2012: 88).

According to Palley, dignity as a philosophical concept refers to a "state of being treated as if your subjective experience, your feelings, preferences, hopes, fears, and self-understanding mattered. When a person receives this kind of treatment from the personnel of a court, a hospital, or a prison, it can be said that these institutions have respected his or her dignity (Palley et al. 2012: 27). Dignity, as a normative concept, emerges from both human rights law and therapeutic jurisprudence. It, moreover, provides an alternative framework in the debate between the need for paternalistic treatment and the need to protect patients' liberty.

Emphasis on dignity, rather than liberty or paternalistic treatment, according to Palley et al, would provide the appropriate balance between our values of both liberty and treatment. Palley et al. argue that too much emphasis on liberty and the presumption of self-mastery can lead to therapeutic indifference (28). Dignity based reforms would make civil commitment

standards less restrictive (Palley et al 2012: 26), thereby meeting the requests of reformers who argue that LPS Act is too limiting.

Dignity based reforms, however, does not forgo autonomy. According to Palley et al, “while dignity is an undeniably important aspect of dignity, it does not exhaust dignity (Palley et al. 2012: 29). Furthermore, dignity means that a person’s subjective perspectives and wishes be respected, not ignored. In other words, though, in some ways, the mental health patients autonomy is violated in the form of involuntary confinement, this violation of autonomy does not equal a violation of a mental health patient’s dignity. Despite confinement, mental health patients can still be shown respect, listened to, and develop meaningful relationships with caretakers (Palley et al. 2012: 43). Lastly, Palley et al. adds that empirical research suggests that individuals who are treated by the authorities in a manner worthy of dignity and trust are more likely to hold positive feelings towards the legal institutions, even when the procedural outcome goes against the subject’s stated wishes (Palley et. al 2012: 41). Palley et.al’s introduction of the normative concept of dignity and their suggestions for dignity based reforms provide an alternative framework for assessing mental health patients’ experiences with involuntary confinement and the law.

IV. METHODOLOGY

A. Methodology Overview:

All research methodologies have their limitations; hence, I believe in choosing a methodology that is most compatible with the kind of research question I am trying to answer. My research is an interpretive study as it seeks to identify subjective world views and motives that lead people (mental health patients) to behave in a particular way. The research questions I ask are theory generating questions since they seek *how* mental mental health patients understand and mobilize the law, and also *how* mental health patients’ experiences are shaped by law. I, therefore, have chosen to use qualitative methodology for my research. I plan on conducting

semi-structured interviews --combined with story collection -- to study mental health patients who have experienced hospitalization due to their mental illness.

Moreover, because my research aims to contribute to the literature on legal consciousness and legal mobilization, both for my theoretical framework and methodology, I will be borrowing, incorporating, and adapting concepts and methods from pre-existing literatures on legal consciousness and legal mobilization. Common methodologies used in legal consciousness and legal mobilization research are surveys, in-depth interviews, and observation (Bumiller 1986, Engel and Munger 2003, Ewick & Silby 1998, Morill et al. 2010). Furthermore, most studies use these methods in combination. I chose, however, to concentrate on conducting interviews due to various limitations. There was the limitation of time in a one year research project. Surveys were challenging because it is difficult to find the population that I am studying (mental health patients who have experienced hospitalization) in large numbers. Observation was difficult due to access. I, therefore, believed that conducting semi-standardized interviews along with story collection was the best and most feasible method for my research.

Lastly, but not least, I find that collecting narratives is a most suitable for the type of research that I am pursuing, which is interpretive or exploratory research. Part of my research is seeking to find, from mental health patients' perspectives, what meanings they attribute to law, rights, and legality. In exploratory research, I believe it is more helpful and informative to allow myself to be guided by my interview subjects, then for me to guide my interview subjects through my questions.

B. Data Sampling, Recruitment, Interviewing:

1. Source/Sampling

The primary access point for my data was through my Understanding Depression DeCal class. DeCals are “student-run democratic education programs” at University of California, Berkeley. Each semester, students, under the supervision of faculty, create and facilitate classes

on a variety of different subjects not addressed in the traditional curriculum. They are typically 1-2 unit classes taken for Pass/No Pass. It is reported that approximately 3,000-4,000 students participate in a DeCal each semester (“About” 2010).

In the Understanding Depression DeCal, students learned about clinical depression from the perspective of the sufferers. The class used personal narratives from memoirs, documentaries, and guest speakers (mostly consisting of UC Berkeley students and faculty) to better illustrate clinical depression and also aimed to remove the stigma attached to mental illness. Through my participation, I observed that many guest speakers spoke about hospitalization experience as a result of their mental illness. Many guest speakers also suffered from other mental illnesses (such as eating disorders and bipolar disorder) in combination with depression. This DeCal was my access point for establishing interview contacts, from there I used snowball methodology to establish further contacts for my research.

I chose this source/sampling method because it is the most feasible way to acquire data for my research. It would be difficult to find mental health patients to study because many are be reluctant to come forward and agree to be interviewed due to stigma. It anticipated that it would be much more feasible to interview those who are already open to sharing their experiences with others. Also, again, it would be extremely difficult to gain access to mental health hospitals, due to hospital rules and regulations.

2. Recruitment

After the class ended, few of the guest speakers had already agreed to doing interviews. I sent a brief description of my research to the DeCal facilitator in December to be forwarded to a list of ten guest speakers. The description was honest, but left out details about law and legality in order to not contaminate the interview subjects. They were told, more generally, that I am conducting research on mental health care issues and hospitalization. Moreover, due to my sourcing it was likely that many of my interview subjects would share certain characteristics.

Thus, I did not use strict requirements to qualify my interview subjects. My two requirements are that they (1) must have been diagnosed clinically with a mental illness at some point, and (2) have experienced hospitalization, either voluntary or involuntary, due to their mental illness.

The email was forwarded, but during the whole months of December and January, I only received one response back for an interview. Needless to say, I found recruitment much harder than I expected. I struggled for nearly two months to establish interview contacts for my research. I planned on having my interviews finished by the end of January, but it took me until late March to establish contacts and finish the interviews. I was surprised to find that even the guest speakers were reluctant and afraid to come forward and be interviewed due to stigma and confidentiality issues. Furthermore, acquiring a snowball sample was also much tougher than I anticipated because many of the guest speakers were reluctant to give out contacts of their friends and family members who struggled with a mental illness due to the sensitivity of the subject. Through a series of email requests, I was able to conduct a total of nine interviews. However, I decided to drop the 9th interview in my analysis when my research started to focus more on involuntary hospitalization and the LPS act. The 9th subject had only experienced outpatient, voluntary hospitalization.

Of course, there are several problems with my method of recruitment and sample. My sample size ended up being smaller than I had hoped. (I had anticipated conducting about 10-15 interviews). Due to my recruitment and sampling method, I ended up interviewing a homogenous sample. Most of the interview subjects, (with the exception of one 61 year old, recovery coach), were UC Berkeley students. The age range was between 19 and 61, but most people were in their early twenties. Most of interview subjects (6/9) suffered from bipolar depression. One subject had struggled with an eating disorder, and the other two struggled with depression. Due to the education level, moreover, it is likely that my interview subjects were more likely to have a heightened awareness of law, rights, and legality. Many subjects, moreover,

were active in some kind of mental health advocacy organizations. Josh, for example, was a recovery coach. Heather served as secretary to a club dedicated to mental health advocacy at UC Berkeley. Roxanne ran her own DeCal class, educating students about mental illness. Lastly, Rachel was an aspiring psychiatric nurse, and had also co-taught the Understanding Depression DeCal.

All these factors contribute to making my sample inherently biased. It is, therefore, important to note that I am not making any generalization regarding the mental health population in my sample. I must acknowledge that the nature of my sample probably led to findings that are biased. For instance, it is likely that my participants had greater awareness of their legal rights, and were more likely to take further legal action in the context of disputes or rights violations due to the education level and their participation in mental health advocacy programs. However, the legal consciousness and legal mobilization has not been studied in the context of mental health patients and hospital settings. Though further research with a broader sample size would certainly paint a more accurate picture, I view my research as a humble starting point, in which we can shed light and begin to better understand how mental health patients both understand and mobilize the law.

3. **Interviewing**

According to Berg, “Interviews are an especially effective method of collecting information ... Particularly when investigators are interested in understanding the perceptions of participants or learning how participants come to attach certain meanings to phenomena or events...” (Berg 1989: 35). My research aimed to gain greater understanding of legal consciousness and legal mobilization from the perspective of mental health patients through the method/art of interviews.

Everyone participating in my research were promised anonymity. All names were changed to protect the identity of my interview subjects. There is one master list which

associates the interview subjects with their pseudonyms, which is to be destroyed after I have completed my thesis. The interviews were in-person, recorded, and then transcribed. The transcriptions were later reviewed and coded for specific themes.

The interview process was organized into parts A, B, and C. But I always started off the interview process with an icebreaker about school or work life to ease into the conversation. Part A of my research asked subjects to simply share a story about their experience with mental illness and hospitalization. The reason for this simple approach was grounded in my experience in the Depression DeCal this fall. From what I witnessed, such simple direction was enough to prompt speakers to share rich information regarding the nature of mental illness, hospitalization, and also their opinions about the mental health care system. Surprisingly, though law was not probed, many guest speakers brought up issues of law (frequently in the context of patients rights and social control) in the process of sharing their stories.

For Part B & C, however, I conducted semi-standardized interviews. This meant that I had a pre-determined list of questions that I want to ask my subjects, but I would also be giving interview subjects to digress when appropriate to gather the richest data possible. In order to facilitate this digression, I used scheduled, as well as unscheduled probes. According to Berg, “questions used in a semi-structured interview can reflect an awareness that individuals understand the world in varying ways. Researchers thus approach the world from the subject’s perspective” (33). Since my research aimed to gain greater understanding of legal consciousness and legal mobilization from the perspective of mental health patients, I found the semi-structured interview format to be compatible method with the goals of my research.

Part B pertained to questions and probes regarding significant episodes in mental health patients experience with mental health and hospitalization. The pre-determined questions and probes attempt to subtly uncover the legal consciousness and mobilization of mental health patients in relation to asking question about places (hospital settings), people, and incidents. For

example, I would ask, “Did the hospital have any rules or polices?” Then, I may probe what he or she thought of those polices, and if it he or she thought it was helpful for his or her recovery.

Lastly, I saved the most controversial questions for Part C. This section included questions and probes about legal consciousness and legal mobilization more directly (if they did not surface already in parts B & C). This section allowed me the flexibility to probe deeper on issues that were brought up earlier in the interview that related to my research question, but that were not in the scope of my understanding.

4. Narrative Analysis:

There are purposeful reasons for why I sought to acquire narratives in part A of the interviews. Firstly, through my participation in the Depression DeCal, I witnessed that storytelling arises naturally. All guest speakers in the DeCal were asked to talk about their experience with mental illness. Some guest speakers came with a planned list of things they wanted to talk about, while others came in with no preparation. But all guest speakers, in the end, spoke about their experiences in a narrative fashion. It was also not uncommon to hear questions answered in this fashion. So far, I have not observed any guest speaker talk about his or her experience as a list of factual accounts that happened to him or her. Ewick and Silby also note this phenomena by quoting Hayden White, who observed that ““so natural is the impulse to narrate, so inevitable is the form of narrative for any report of the ways things really happen, that narrativity could appear problematic *only* in a culture in which it was absent”” (Ewick and Silby 1995: 197).

Secondly, I believe narratives as a source in investigating how mental health patients understand and use law in their lives, and simultaneously how their lives are shaped by law. The stories helped me to investigate how awareness of law and legality were already present in the lives of mental health patients. Stories were also a less biased way of studying law, since asking direct questions about law may only prompt answers in which the subjects tell me what they

think I want to hear about law. Hence, I feel that narratives would be a more authentic way to gain insight into how mental health patients understand and use the law.

Thirdly, in one of Ewick and Silby's articles, they argue that "narratives are socially organized phenomena which, accordingly, reflect the cultural and structural features of their production" (Ewick and Silby 1995: 200). Moreover, they argue that narratives have the capacity to both expose hegemonic relations because they "...bear the marks of existing social inequities, disparities of power, and ideological effects..." but at the same time are able to subvert hegemonic relations because "...they also provide opening for creativity and invention in reshaping the social world..." (Ewick and Silby 1995: 222). The capacity for narratives to expose the often taken-for-granted hegemony in social relations and structure was crucial for my research because of the ambiguous and unequal power relations in hospital settings.

Furthermore, collecting narratives, rather than just conducting semi-standardized interviews, added an important value to my research data. According to Maynard-Moody & Musheno, "...stories offer kinds of information that are rarely found in interviews ... [they] allow the simultaneous expression of multiple points of view because they can sustain and suspend multiple voices and conflicting perspectives, ... [they] can also present highly textured depictions of practices and institutions..." (Maynard-Moody & Musheno 2003: 29). Moreover, "[i]n contrast to more standardized interviews, one benefit from collecting stories is that they are likely to include complex, thick descriptions, although such results are not assured." (Maynard-Moody & Musheno:28).

Lastly, stories are significant as they "give prominence to human agency ... and are told to express and sustain the values of a particular society or subgroup" (Maynard-Moody & Musheno 2003: 30). Part of my research aimed to give voice to the mental health patients through the art of storytelling, who are commonly left out in the scholarly debates regarding law and mental health issues.

VI, ANTICIPATED FINDINGS

The nature of my research is exploratory, hence I do not want to bias my research and analysis with pre-determined expectations of what I may find. That being said, however, I will be making few preliminary propositions based my participation in the Understanding Depression DeCal this Fall and on the literature I have reviewed.

After listening to many stories about mental illness and hospitalization from guest speakers, I will not be surprised to find if various forms of social control in the hospital setting that shape mental health patients' understandings about law, and also affect how they mobilize the law. One guest speaker spoke about zero-tolerance policy in her eating disorder treatment center. She claimed that this policy led her to keep "getting kicked out" of the treatment setting, hence interfering with her treatment in a non-sensical way.

Moreover, after reviewing literature on mental health from various fields including legal, medical, and psychiatric (Vigoroff & Ross 1969, Grisso & Applebaum 1998, Johnston and Planansky 1976), I propose that the dispute pyramid will be wider at the base than the traditional dispute pyramid, because the number of unperceived rights violations will be greater. A rights violation may be seen as an act of treatment in the case of mental illnesses (e.g. involuntary hospitalization). Because many physicians will tend to frame issues as treatment or medical issues, rather than legal ones, rights violations may go unnoticed. Hence, instead of the triangular shape, the dispute pyramid for mental health patients may look more like a witch's hat (wide at the bottom, narrow at the top). Secondly, I make the proposition that a greater number of mental health patients will choose to "lump it" due to the discouraging unequal power relations between physicians and patients (Szasz 1974).

Lastly, the literature guides me to look for various barriers to legal mobilization. The socio-legal literature identifies both structural (e.g. time & money) and psycho-social barriers (e.g. not wanting to be labeled a victim) as a barrier to legal mobilization (Bumiller 1986). But

based on additional literature on mental health, I propose that mental health patients would have more barriers to legal mobilization. One may be competency, since there is a lot of controversy (both from legal and medical) regarding whether mental health patients should have the capacity to exercise their rights (Saks 2002). I will be basing few of my interview questions to probe for these kinds of barriers. Again, I want to re-emphasize that though the literature acquaints me with various potential barriers for legal mobilization, I am more interested in exploring how mental health patients see the legal mobilization process, and what they identify as barriers to legal mobilization.

V. FINDINGS

A. Legal Consciousness

Social-legal scholarship traditionally distinguishes between law on books and law in action/lived law. My findings revealed a discrepancy between how involuntary civil commitment law (LPS Act) was on the books, versus how it was lived and experienced by mental health patients in real life. Despite the LPS Act's commitment to liberty, most mental health patients were too afraid to exercise their rights in the hospital setting. Most patients were under the impression that they did not have many rights due to their status as a mental health patient. They were also the impression that they had to obey the rules, out of fear that there might be negative consequences. Others, such as Jessica, were discouraged in trying to mobilize their rights because they didn't feel they were treated with respect in the hospital, and thus felt nobody would listen to them if they tried to assert their rights in anyway.

Fascinatingly, moreover, despite the active participation in mental health advocacy and educational level of my participants, no one knew the full extent of how their patients rights could protect them. Most mental health patients remained ill-informed of their patients rights, and, in some cases, even misinformed. Though patients rights had some sense of symbolic importance to most mental health patients, for the most part, mental health patients had little

faith when it came to exercising their rights. In the following, I give a summary of patients rights under the LPS Act as it is written on the books. I then contrast them with responses I received regarding patients rights from my interviews.

Patients Rights Under the LPS Act:

The LPS Act does entail restrictions of a patient's basic human liberties such as the right to have one's own clothing. Under the LPS Act patients are to maintain all rights unless specifically denied under the the LPS statutory scheme (Welfare & Institutions Code Secs. 5325.1 and 5327). However, the LPS act states various "undeniable rights" codified under section 5325.1. They include the following:

- A right to dignity, privacy, and humane care.
- A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse or neglect. Medications shall not be used as punishment, of the convenience of staff, as a substitute for a program, or in quantities that interfere with the treatment program.
- A right to prompt medical care and treatment.
- A right to participate in appropriate programs of publicly supported education.
- A right to social interaction and participation in community activities.
- A right to physical exercise and recreational opportunities
- A right to be free from hazardous procedures.

(Welfare and Institutions Code 5325.1)

Good Cause for Denial of Rights:

Under the LPS Act, patients' rights (excluding the rights to refuse convulsive or insulin coma treatment, psychosurgery, and the right to see an advocate) may only be denied by the professional person in charge of the facility, or his or her designee, for good cause.

A good cause is believed to exist when:

- 1) exercise of the right would be injurious to the patient/resident OR
- 2) there is evidence that the specific right, if exercised would seriously infringe on the rights of others OR
- 3) the institution or facility would suffer serious damage if the specific right is NOT denied

AND there is no less restrictive way of protecting the interests specified in 1, 2, OR 3.

In addition, a right cannot be withheld or denied as a punitive measure, nor can a right be considered privilege to be earned or be denied as part of a treatment modality. Lastly, denial of a patient's rights must be properly documented. (Welfare and Institutions Code SEc. 5325 and 5326).

Rights to Exercise Informed Consent Medication:

Under the Welfare Institutions Code 5152, information (both oral and written) is required to be given to patients for informed consent to refuse medication. Patients must be provided with all essential information regarding the medications they are being prescribed, including the probable effects and possible side effects of medications, the likelihood of improving or not improving without the medication, and reasonable alternative treatments available.

Furthermore, under California Welfare Institutions Code Section 5332, medication may be administered *if* that person does not refuse that medication following disclosure to the right to refuse medication. If he or she has refused medication, the medication is to be only administered upon determination of a person's incapacity to refuse treatment OR medication may be administered in a case of emergency situation in which actions to impose treatment leads to harm to self or harm to others. (California Welfare Code Section 5332).

Riese Hearing (Capacity):

In *Riese v. St. Mary's Hospital Medical Center "Riese"* (1987) the court recognized that persons detained under the LPS have a right to give or refuse consent to medication prescribed

for treatment. Importantly, moreover, *Riese* recognized that mental health patients may not be recognized as incompetent solely because of their involuntary hospitalizations (Welfare and Institutions Code Sec 5326.5 and 5331). Following the court decision in *Riese*, California legislatures enacted SB 665, mandating informed consent, and capacity hearing procedures. Under the implementations of *Riese*, the burden of proof rests on the prescriber/petitioner to determine a patient's incapacity. In other words, a patient is presumed to be engaging in a rational thought process until proven otherwise.

Assessing capacity under the *Riese* guidelines provided by the court focus on whether a patient:

- 1) is aware of his or her situation
- 2) is able to understand the benefits and risks of, and alternatives to medication
- 3) is able to understand and evaluate the medication information and participate in the treatment decision through a rational thought process.

Under these guidelines, it is acknowledged that doctors and patients are able to disagree on issues of treatment (e.g. medication), as long as they both agree that a patient does not lack capacity.

What are my patient's rights anyways?

Mental health patients had very little understanding of what their patients rights were on the books. When I asked how they first came to know about their patients rights, most people referred to them as a stack of papers they were given to sign the first night at the hospital. "They probably told it [patients' rights] to me while I was medicated ... I don't remember them ever, I mean maybe when I first got there, but that was like at 4 A.M. and I was out cold, because I don't even remember going there." Rachel similarly noted the experience: "they give you a form, I mean you're coming in, you're not really in a good state, and they give you some form, and you sign it. You get a copy of it, and it says patient's rights" (Rachel).

Similarly, not only were mental health patients unaware of their patients rights, but in many cases they were also misunderstood or misinterpreted. Thus, there were some notable inconsistencies from what the law stated on the books to how it was actually lived by patients. A few examples included that under section 5325.1 of the California Welfare and Institutions Code, patients had the “undeniable rights” to dignity, privacy, and humane care. Yet, many interview subjects, including Jessica and Elaine, argued that they didn’t feel they were treated with dignity and humane care at the hospital. In fact, Jessica even said that she “ didn’t feel like she had a place as a human being.”

Moreover, Max and Josh both believed they were in imminent threat of physical violence if they did not obey the rules properly. But again, under the “undeniable rights,” patients had the right to be free from harm, including unnecessary or excessive physical restraint, isolation, abuse or neglect. Also, medications could not be used as punishment (Welfare and Institutions Code 5325.1). Josh may have had a plausible reason in believing that he was under imminent threat of physical violence for violating the rules because he mentioned an episode where a security guard nearly knocked him to the ground for taking some toilet paper out of the bathroom. Meanwhile, Max firmly believed that the nurses had the power to shoot people up with Risperidone, if patients did not do as they said.

In addition, under the implementation of *Riese*, patients are not assumed to be incompetent based on their involuntary status. However, many patients questioned their own competency, or believed the hospital staff did not recognize them as competent due to their mental illness and status as an involuntary patient. Also, under *Riese*, the burden of proof rests on the prescriber or petitioner to determine a patient’s incapacity (Welfare and Institutions Code Sec 5326.5 and 5331). However, not only were mental health patients unaware of this standard, they also frequently used the discourses of “competency” rather than “capacity” to describe their lack of mental or education abilities.

Though most mental health patients recalled receiving a form, they had little knowledge of what it said or meant. In fairness, however, mental health patients entered the hospital at their most vulnerable states (such as after attempting suicide), hence their low energy and consciousness states discouraged them from actively looking through the stack of papers. Elaine mentioned this exact point when she said:

““Oh, I’ll just give her the information, but I won’t actually state it or explain it so, that she doesn’t. That she’d only know about it if she goes looking for it. And really who’s going to go looking for your rights when you’re in a mental state, or emotional state where you are scared and in pain?” (Elaine).

Both Josh and Jessica also commented on the fact that there was nobody around to educate them about patients rights and self-advocacy. Jessica said she actively sought out information regarding her patients rights in the hospital, but all she found were pamphlets explaining the criterion for the LPS Act. Lastly, Heather also commented on the problems of mobilizing the law because it was hard to recall the long list of patients right, and very easy to confuse them.

Since mental health patients did not have much knowledge of their patients’ rights on the books, they were not likely to mobilize those rights. Nevertheless, despite not knowing their rights, many interview subjects stated that they were still valuable to them. For most, their patients’ rights came to hold some sort of symbolic significance. To mental health patients the patients rights symbolized choice and meant that [the doctors and nurses] will “treat [them] like a human being.” It also symbolized that the doctor’s didn’t have full control over them, and that there was a check on their power. Hence, despite the fact that mental health patients did not know their patients rights, they felt that, in some symbolic sense, it was important to have them.

Aside from possessing little knowledge of what their patients rights were, mental health patients also had very little faith in their patient’s rights when it came to actual practice. They

acknowledged that though the patient's rights theoretically granted them choice, exercising choice would be unlikely in practice due to both issues of competency and their vulnerable status as patients:

“Am I fully entitled to my rights? Yes. Will they get worked out? No, mostly not. I mean if you were to take a case about patients' rights, it would have to be like really serious beating of people where you left marks on people, and you'd have to prove that you weren't crazy, and that it actually happened ... so I mean to me, now I know they exist, but I wouldn't expect them. I would look out for myself” (Max).

Moreover, many mental health patients also felt that there were other means of protecting themselves from harm, and getting their needs met in the hospital setting. Rather than patients rights, mental health patients expressed reliance on the self, family, ethics, and their ability to perform competence. For instance, Roxanne repeatedly mentioned how fortunate she was to have a family who looked out for her best interests. Max said he would look out for himself, and also said he relied on the ethics of the higher ups to “do the right thing,” and not abuse their given power. For Rachel, she relied on her ability appear “normal” and competent in front of nurses and staff to get her needs met. She said that when she was hospitalized at John George, she “pulled every ounce of maturity, wisdom, and composure” that she could do get herself out of the horrible hospital environment.

5150: Stigma and Status

Similar to how the ADA (American Disabilities Act) changed self-perceptions and discourses of disability for those who were disabled (Engel & Munger 2003: 241), the Lanterman Petris Short Act (otherwise known as the 5150) played a significant role in shaping mental health patients' identities. The LPS Act provides the criterion for involuntary civil commitment in California. Simply put, the criterion states that when one is either danger to self,

danger to others, or gravely disabled, they can be legally held in a psychiatric hospital for three days. The law intended to end indefinite and inappropriate civil commitment. However, mental health patients frequently mentioned the stigmatizing status of being placed under the LPS Act. For them, being 5150ed meant being marked as the “crazy person.” As Rachel put it:

“I took a bunch of diet pills and I had to go to the hospital, and I got 5150ed again, which means that they take you against your will, and I’m always getting 5150ed at this point, like okay, I’m going don’t worry, you don’t have to strap me down. And then you’re just like the crazy person, you’re that crazy anorexic girl” (Rachel).

Jessica also felt that she was branded as a “crazy person” after she was 5150ed and tried her best to get it off her record. She stated:

“And I just felt like if anyone goes and looks at my medical record, then they see that I had a 5150, like I can’t get jobs, I can’t do a lot of work in public services, with that on my record, you know? Like people are not going to want somebody like that to be working with them...” (Jessica).

Though Jessica believed that her medical record, much like a criminal record, was readily discoverable by employers, Title I of the ADA Act prohibits discrimination in recruitment and hiring based on an applicant’s physical and mental disability. It further restricts questions that can be asked about an applicant’s disability and provides that medical records be confidential with limited exceptions (The U.S. Equal Employment Opportunity Commission: 1). Thus, despite the law’s definition on the books, the LPS Act had a different social significance and definition for mental health patients. While the law originally intended to serve mental health patients by ending inappropriate and indefinite psychiatric holds, mental health patients were more likely to hold negative opinions regarding the law due to its stigmatizing association.

Interestingly, however, a few mental health patients chose to claim their stigmatizing identity as a marker of deviance. For them, the the stigmatizing marker of the 5150ed gave them status. For example, Elaine stated:

“I would look around me, and I would see all these old crazy people. And I say crazy because I’m allowed to, we established the rule in that ward that no one else could call us crazy, not even the doctors, no one else could, but we could. We could call ourselves that because we are, and it’s offensive when anyone else did it, you know? [laughs]” (Elaine).

Thus, for a few mental health patients such as Elaine, claiming the 5150 status meant defining some sort of deviant, in-group status.

Legal Mobilization

In order to investigate the legal mobilization process for mental health sufferers, in Part B of the interview, I asked subjects if they ever had an instance where they felt “mistreated,” “humiliated”, or “wronged” to probe for any disputes that may or may not have lead to legal mobilization. In Part C, of the interview, moreover, I asked subjects directly if there was ever an instance where they exercised their rights in the hospital setting. All subjects, except one, stated that they had an instance, or instances where they felt “mistreated,” “humiliated” and/or “wronged.”

As anticipated, however, majority of the mental health sufferers I interviewed decided to lump any incidents in which they felt “mistreated,” “humiliated,” and/or “wronged.” Many also failed to contextualize these incidents/disputes as legal, and hence did not seek out formal, legal remedies. Many felt that there weren’t remedies to much of these incidents that happened in the hospital (legal or otherwise), and decided to simply accept them as part of their hospitalization experience. As one interview subject put it, “It’s just people being people, I felt like.” The second most popular recourse was engaging in extra-legal remedies, such as talking to peers, counselors,

or family members. A few resorted to quasi-legal action by using some sort of internal grievance procedure to remedy their disputes.

To better contextualize the process of legal mobilization of mental health sufferers, the following are few narratives that highlight some of the incidents that my interview subjects encountered in the hospital setting.

“Lumping” (a.k.a. Doing Nothing)

Josh, diagnosed with bipolar disorder, was hospitalized after a suicide attempt. Josh was hospitalized at the John George Psychiatric Pavilion. John George Psychiatric Pavilion, commonly referred to as “John George,” is hospital run by the county of Alameda. It is known to have a horrible reputation for both its facility and treatment. While at John George, Josh recalled an incident where he was almost physically assaulted by the security guard after taking a roll of toilet paper out of the bathroom: “He charged at me, and screamed at the top of his lungs, and came probably within six inches of me, and I thought for sure he was going to knock me to the ground” (Josh).

Josh had asked the nurse’s permission prior to taking the toilet paper out of the bathroom, and the nurse came to his defense just before the security guard knocked him to the ground.

Nevertheless, Josh mentioned that he felt mistreated, humiliated, and traumatized by the incident, and said it was the “worst things that has happened in [his] life.” After the incident, he retreated back to his room.

Heather was hospitalized for her depression also after a suicide attempt. Heather’s depression was linked to her physical disability. She had a severe case of scoliosis that lead to spinal fusion surgery. The surgery still left her in chronic pain, which contributed to her depression. When asked if she ever felt wronged, she mentioned an incident where a psychiatrist inappropriately touched her during a session:

“... He had his hands under my shirt and [was] like feeling my muscles, my back muscles. And he was like, ‘Come closer’ ... And then he was rubbing my back under my shirt. And I was like, this is really weird. Then I sat down, and I was suppose to tell him my story and then he takes my hand and rubs my hand, and was like, ‘Oh, you’ve been through a lot, haven’t you?’ And it was really weird, there was just something about it” (Heather).

Heather later found out from the hospital staff that the psychiatrist was not allowed to touch any of his patients. She was given paper work to file, but she never ended up filing the paper work. She said she felt uncertain, and wasn’t sure if she was “blowing it out of proportion.” She also said she was afraid what would happen, especially because she had no direct evidence against the psychiatrist. Though she chose to lump it, she now wishes she had filed those papers.

Rachel who was hospitalized numerous times for her eating disorder said she felt wronged all the time, but rarely did anything about it. She said:

“For example, my inhaler not coming in, which has nothing to do with mental illness, and then them [the staff at the hospital] not dealing with it or getting it because I wasn’t throwing a fit or because I wasn’t having an asthma attack, but I was just really uncomfortable, and it kind of gives me anxiety when I can’t breathe ... I mean you keep asking, and eventually someone will get it .. I mean whatever ... what if anything ever gets done.”

Rachel described feeling “mistreated,” “humiliated,” and “wronged” as simply part of the hospital experience, and thus not much could be done about it, legal or otherwise.

Max suffered from bipolar depression as well as psychosomatic aphasia and psychosomatic paralysis, which led to his first in-patient hospitalization. Max said he went “voluntarily” because he was given the “choice” between going voluntary, in which case the

insurance company (Kaiser Permanente) would pay for his hospitalization, or going involuntary under the LPS (515) Act, in which case his insurance company would not pay for his stay. The guidelines under the LPS Act state that faculty can only place a person under the 72 hour hold if they had first been offered the option of voluntary treatment, and refused (Welfare and Institutions Code 5250). This guideline is perhaps what the nurse was referring to, but somehow her interpretation and application sounded much more misleading and coercive than the intended guidelines.

Hence, Max said he “chose” to go voluntarily.” He also said the nurse at the hospital warned him that going involuntary would mean he could be sent to John George (a psychiatric institution with a horrible reputation). He chose to go voluntarily because going involuntarily would be too much of a financial burden. In that sense, he argued he really did not have a choice. To add insult to injury, he said he felt wronged when they [the doctor/staff] told him:

“Either you stay here, or we’ll keep you her.” Max argued, “There was a terminal end date to that [his hospitalization], but wait, I can’t get out? I’m done, but I couldn’t get out. They would put me on 5150 again, because I wasn’t on a 5150. I was voluntarily there, so they could just hit me with a 5150 and I would be stuck ...”

He furthermore mentioned that eating with a spoon in front of a group (because hospital policy would not allow forks or knives in the hospital) was particularly humiliating. He also mentioned that he felt mistreated when the psychiatrist switched his medications a couple of times without informing him why. Despite these incidents, he said he did not do anything to remedy these instances because during his hospital stays, he felt too “depressed” and “apathetic.” He also argued that he recognized much of these incidents as mistreatment, humiliation, or wrongs only after he got out of the hospital. When asked if he would have done something about these incidences in hindsight, he replied, “I didn’t have the opportunity. I mean the whole thing is that I wouldn’t be in there if I had the opportunity.”

Extra-Legal and Quasi-Legal

Rachel recalls one particularly bad incident at John George Psychiatric Pavilion where she felt humiliated and wronged. She stated that there was no reason for her to go there because she had “okay insurance.” However, she got sent there due to a shortage of beds at Herrick (another psychiatric hospital with a better reputation). She also added that “they just didn’t give a sh*% about [her], and they just wanted to get [her] out of there.” Out of numerous hospitalizations she experienced throughout seven years of struggling with her eating disorder, she stated that the John George was her most humiliating experience. She stated:

“Oh my god, I don’t think I can ever step foot n that place, unless I’m making some kind of change or saving someone else from that. Oh, it’s just a horrible place ... [the nurse] was so nasty, just cold, judgmental, and harsh. Oof! And then they take all your clothes, they take EVERYTHING, EVERYTHING from you, which they don’t do at every psyche ward.... And the [hospital gown] was too big, and so I had to hold it so I wouldn’t be exposed the whole time... then we got into a giant auditorium, which was like a holding cell with padded walls. ... And I was just disgusted. ... like someone had smeared their feces and so they were cleaning them up, and there was a girl who was having seizures every 10 minutes ... and there was a crazy guy who kept talking to me. I mean obviously we were all crazy; we were in the psyche ward. But he was probably like some psychosis from drugs or something, and it was just really uncomfortable ... and yeah, I was in there for 18 hours, and I just stood the whole time because there was no where to lie down”

Rachel managed to get herself released from John George and transferred to a different hospital by verbally convincing the authority figures that she was not a threat to herself and that the environment was going to be more detrimental to her current mental state (extra-legal).

Rachel also added, however, that more often than not she did not speak about instances where she was humiliated or treated poorly, except maybe at outpatient programs, because she knew that everyone had had similar experiences (extra-legal).

Roxanne said she felt mistreated when certain male patients at the hospital went around and “ruffed up girls skirts.” To remedy the situation, Roxanne first addressed the issue verbally to the staff. She stated that the staff did their best, but they weren’t doing enough, so she herself went to security to further remedy the situation. Even though she felt mistreated and felt that the staff wasn’t doing enough, she stated that the situation was not a big deal because the male patients themselves were mentally ill, and therefore could not help themselves.

When asked if Josh had ever had an instance where he decided to exercise his right as a patient, Josh recalled another incident of being wronged during his stay at Oakland homeless project, which served as a transition house after he was released from John George Psychiatric Pavilion. He said he encountered a staff member who abused the the patients/residents there “verbally, emotionally, [and] racially [by] manipulating situations. He said she engaged in petty behaviors that left him annoyed, humiliated, and disempowered. He gave one example where patients/residents would line up for their medications, but the staff member would purposely break up the line if there there were people in front of the line whom she didn’t like. Josh stated that he used his rights by verbally defending himself against the staff (extra-legal). He brought up the issue to other staff members who encouraged him to file a complaint against her, and Josh followed suit. Josh later found out that the abusive staff member was eventually fired (quasi-legal).

Moreover, Josh, working now as a recovery coach (or mental health advocate), even stressed the value of extra-legal remedies. He stated that support from recovery coaches can help mental health patients mobilize the law by providing patients with information as well as emotional support. He also emphasized the relatively equal power relationship a mental health

patient has with his or her recovery coach, mentioning that recovery coaches call their clients “partners.” He argued that since many people are afraid to mobilize due to the relative control staff members, nurses, and psychiatrist have over mental health patients lives, patients would feel more comfortable sharing their experiences and mobilizing with recovery coach’s assistance.

Formal

Jessica was the only person I interviewed who mobilized the law formally; she contacted a lawyer after she was released from the John George Psychiatric Pavilion. Jessica, moreover, pursued a formal strategy in concert with other strategies including extra and quasi-legal. Jessica’s bipolar depression started to surface during her first years in college. During one of her bipolar manic episodes, she had turned violent (biting somebody) and eventually blacked out from heavy drinking. The following day, her mother and aunt took Jessica to the hospital for a psychiatric evaluation. The doctor, after examining Jessica, told her family that she did not need to be admitted to the hospital at this time. Jessica would still receive treatment, but the doctor felt there was no need for an inpatient hospitalization. He told Jessica and her family that a hospitalization would possibly traumatize her more. After the evaluation, Jessica said she went out to smoke a cigarette. Meanwhile, Jessica’s twin sister and her close friend got in a fight over Jessica’s mental health issues, which lead to physical violence outside. The security guards were called out, and mistook Jessica for Jessica’s twin sister. Though Jessica’s family came in defense of Jessica saying that it was not her but her twin sister who got in the fight, Jessica was nevertheless placed under a 5150 and sent to John George involuntarily.

Jessica was driven to mobilize the law because she saw her involuntarily hospitalization as illegitimate and as a case of false imprisonment due to mistaken identity:

“I felt like my rights were fricken’ obstructed, especially because they took me in, because they thought I was my sister, I wasn’t doing anything ... I felt like I’m not

suppose to be there.” Though Jessica was mostly driven to mobilize the law due to her mistaken identity, her interview also revealed that her mobilization was also connected to concerns of procedural justice: “Like when I got out, I was talking to my family, I want to sue these people. I didn’t feel like they treated me right at all, they treated me like s*#@, like they didn’t care or whatever.”

Upon release, Jessica said she called various people to see what she could do about her situation, in addition to doing research on the internet (extra-legal). Jessica met and spoke with a lawyer regarding her case of mistaken identity. She asked the lawyer for legal advice on what sorts of actions she could take (formal). She was informed, however, that she did not have a case because the doctor (or her hospitalization experience) did not cause her long-term harm. Jessica, however, argued that her hospitalization experience did cause her long-term harm because it skewed her whole perception of the medical field. She said the experience left her very paranoid and scared to trust authority. After speaking with a lawyer and finding out that she did not have a case, she said she felt discouraged to pursue her case further. She added, “Like okay, I kind of just stopped pursuing it because I felt like, well, no one is going to believe me. I’m just going to look more like a crazy person.”

Jessica also spoke to her family about her case (extra-legal), but her family wasn’t supportive of her grievance, because they never fully acknowledged the existence of Jessica’s mental illness. Instead, Jessica’s said her family believed it was Jessica’s choices and bad influences in her life that led to her hospitalization; and hence, Jessica was ultimately responsible. Jessica said, “So basically, [they thought] if I changed my ways, I would be fine.”

Furthermore, Jessica said she also called various people to see if her medical records can be changed (quasi-legal). Jessica found out, however, that it unlikely that she could get her medical record changed because she had no real evidence. The security guards had never made a report of the fight that broke out, and all the witnesses were Jessica’s friends and family

members. Jessica also added, "... so it's kind of like the doctor could say anything, and that could make it seem like he had legitimate concerns to put me in, and I really don't have evidence to the contrary."

Jessica also expressed the frustration she felt and the complications she experienced while trying to get her records changed. She said:

"Okay, this is what doesn't make sense. If you're going to change the medical record, but you're going to go off of what the medical record says to prove if you should change it or not, it's kind of like, well, that's what's wrong in the first place, so how are you going to go off of that? And so that didn't make sense to me, and she was like, 'We can't change your medical record because the doctor's transcription of what went down doesn't show anything different should have happened ...'"

Jessica thus was able obtain a copy of her medical record, but she was unsuccessful in getting it changed. She mentioned that she is still looking into getting her medical records changed, perhaps by going in front of a judge and asking to get her medical records cleaned without pursuing charges against the doctor. But she added that she hasn't been able to find any solutions so far.

Lastly, Jessica said did not mobilize inside the hospital setting, aside from looking at some pamphlets to possibly find information that would help her case. When asked why she did not exercise her rights in the hospital setting she said, "I didn't feel like anybody would listen... I didn't feel like I had a place as a human being. I felt like, my position was to be like a crazy person that was under their control to watch, and whatever they said, I had to do. I didn't feel like I had a say in anything."

Explaining Legal Mobilization: Barriers

Barriers to Legal Mobilization

Socio-legal literature recognizes many barriers to the legal mobilization process, both structural and social/psychological (Bumiller 1986: 421). Though there are many disputes in our social world, whether perceived or unperceived, very few make it to formal adjudication due to barriers. Mental health patients certainly encountered both structural and social/psychological barriers to their legal mobilization process. Most recognized these barriers as limitations to the legal system. For example, when asked if the legal system is an effective tool to fight grievances and wrongs, Elaine answered: “I think that’s a lot of red tape ... you can’t go directly to the source, or the person who can fix it. I think you have to file complaint after complaint, and most people don’t have the time, the energy, the money to do that.”

Though structural barriers were a problem for mental health patients, social/psychological barriers were more prevalent and significant. In the following, I share my findings and analysis that will introduce new, specific themes to the legal mobilization process for mental health patients, as well as elucidate existing barriers. Lastly, anticipated barriers such as power and competency also played a significant role in the legal mobilization process for mental health patients, and I discuss them below.

Mood and Mobilization

Felsteiner et al’s research findings discussed the naming, blaming, and claiming process of legal mobilization, which are psychological processes. Not surprisingly, those who suffered from mental illnesses, had difficulty with the naming, blaming, and claiming processes. Due to feelings of depression, apathy, and low-self-esteem, many discussed only being able to “name” experiences of mistreatment, humiliation, or wrong in hindsight. As Max put it:

“Eating with a spoon in front of the group, that was humiliating. Mistreated? getting different meds, I didn’t know why they were there, but it felt like a mistreatment. And a lot of this is in hindsight, because I was flat, I was apathetic. It’s easy to mistreat or humiliate someone who has no will to live. I mean it really is not difficult. I think that’s

why he was able to get away with so easily. They didn't abuse it too much in my case, but it did exist" .

Moreover, even when they recognized wrongs in hindsight, many, including Max, felt it was too late to do anything about it, and thus were more likely to do nothing. Feelings of low self-worth, depression, apathy limited mental health patients' psychological ability to recognize disputes, and thus barred the legal mobilization process.

There was, moreover, a notable connection between a patient's self-esteem and the naming, blaming, and claiming process of legal mobilization. As one interview subject, Josh, put it, "So I had high self-esteem, I've had a good life, I've had a life that functioned well for a long time, so I recognize what's possible. I recognize what's fair and what's right". He also mentioned his self-esteem when he discussed an experience in which he took quasi-legal action against an abusive staff member at the Oakland Homeless Project. He was motivated to file formal complaints against a staff member who was eventually terminated for abusing patients. Josh remarked that his self-esteem was connected to his ability to "name" a wrong, and also recognize the potential for remedies to his wrongs.

It was more common, however, for interview subjects to discuss feelings of low-self-worth. Max pointed out that it is very easy to mistreat or humiliate people who do not have the will to live. Similarly, when I asked Rachel if and why she did not do anything about being mistreated, humiliated, and/or wronged, she replied, "I don't know. You're just like, whatever. You just feel like a piece of s\$% anyways so. I think everyone there is just like humiliated". Therefore, low self-esteem and feelings of depression for Rachel and other interview subjects was a barrier to mobilization. Moreover, Rachel's statement revealed that when suffering from low self-esteem, depression, and stress, there was a greater tendency to simply accept mistreatment, rather than to challenge it. Mostly they felt it that they didn't feel qualified to

challenge it or that they simply did not have the mental, physical, or emotional energy to do anything about it.

In sum, my findings suggest that certain emotional and psychological standards need to be met in order for mental health patients to mobilize the law. In many cases, mental health patients were “doubly doomed” in terms of climbing the legal mobilization pyramid because they already suffered from feelings of apathy, anxiety, and/or hopelessness due to their mental illness. I noted earlier in my literature review that those who feel hopeless, scared, or fearful of retaliation are more likely to “lump.” This was even more true for mental health patients who constantly suffered from depressive feelings and mood. In this way, the nature of mental illness itself was a barrier to legal mobilization. Lastly, levels of self-esteem played an important role in a mental health patient’s ability to name, blame, and claim grievances, because they saw themselves as a person capable of exercising the law, and worthy of receiving remedies.

Life Before the Law

Though the stories that I collected entailed instances of mistreatment, humiliation, and wrongs, most framed their stories as stories of struggling with their mental illness and recovery. These stories of struggle and recovery were entailed and in many ways were entangled with the law (wether they were involuntarily committed to a psyche ward under the LPS Act, or wether they were arrested during one of their bipolar manic episodes). However, getting better, and dealing with their mental illness in their every day lives were the primary focus for mental health patients. Josh described dealing with a mental illness as a 24 hour task. Most had to postpone their college education in order to deal with their mental disorder. Elaine, Rachel, and Roxanne reported taking significant time off in order to deal with their mental disorder. For example, for Roxanne, living with her bipolar depression meant constantly living in anticipation of what is to come:

Everyday life for me is like, waking up and not knowing what I am going to get.

Everyone wakes up and doesn't know what they are going to get. But I don't know if I am going to wake up to a mind that is going to work for me or not. I could study for an entire month on a test, and on the day of the test, I could wake up and my mind could just refuse to do anything" (Roxanne).

For the most part, concerns about their mental health plagued the consciousness of mental health patients; and thus, law, rights, and legality were swept to the side. When I asked Max when he became familiar with his patients rights, he replied:

"Quiet a while after. I didn't know about patients rights. I didn't really think about it too much, you get out of it, and you try and deal with life. Life is pretty stressful as it is. I mean the thing about patients rights is that you have to care enough to do it after you're out or during when you're there. When you're either extremely depressed or extremely stressed, and neither of them work very well."

Thus, for mental health patients, their mental illness was something they could not easily put aside or ignore; whereas incidences of mistreatment and wrongs could. Moreover, their mental illness consumed enormous amounts of their time, energy, and resources; hence, they were less likely to mobilize the law for these reasons.

Competency: Am I Crazy, or Am I Competent?

Competency was a barrier because mental health patients either questioned their own competency (subjective barrier) or thought nobody would believe them or take them seriously due to their mental illness (objective barrier). The physician or lawyer's ability to judge competence was not a factor for most subjects. Instead, competency was self-defined, or self-questioned. In many cases, mental health patients both questioned their own competency, and doubted whether or not others would render them competent or "crazy." Competency, for

example, played a big role in Heather's decision to mobilize the law. After her encounter with a psychiatrist who touched her inappropriately, Heather was informed by the staff members that the psychiatrist was not allowed to touch his patients, and was given papers to file against the psychiatrist. Yet, Heather was reluctant to file the papers because she said she wasn't sure if she was "thinking it out of proportions or not." Heather added that she had no proof to present against the psychiatrist and thus her case would be difficult to prove. And her position as a mental health patient made filing papers against a psychiatrist feel vulnerable and fearful. For Heather, she had a difficult time naming the dispute, because she questioned her own competency to perceive the situation as a serious dispute. Moreover, she resorted to lumping, because she felt that without clear, strong evidence, others would not believe her or take her case seriously.

Jessica also experienced competency as a barrier when she tried to mobilize the law. For Jessica, she was often discouraged from mobilizing the law, because she felt others perceived her as "crazy" and not competent. For instance, when she felt mistreated or humiliated in the hospital, she was deterred from doing anything about it inside the hospital setting because she felt no one would take her seriously due to her position: "I felt humiliated when I talked to the people at the phone and I was talking about the phone number, they made me feel like, 'Why should we take you seriously? You're just some crazy person'" (Jessica). Likewise, Jessica said she was discouraged from pursuing her case any further after she spoke with a lawyer, because she feared people would perceive her and her actions as crazy. She said, "I kind of just stopped pursuing it because I felt like, Well, no one is going to believe me. I'm just going to look more like a crazy person keep trying to prove this, when they're like, 'No, you can't'" (Jessica).

Both Max and Rachel, moreover, commented on the issue of competency for mental health patients and the legal system. Both Max and Rachel saw using the legal system as problematic and ineffective for mental health patients due to issues of competency. Max argued:

“I mean there are things about the cases that make them difficult inherently, like the fact that you’re dealing with mood disorders, and some of them hallucinate. You’re dealing with huge obstacles that you have to prove are not the case, that this really happened as it was said. And realize also that if you had any witnesses, they’re also nuts” (Max).

Similarly, Rachel commented:

“It would have had to be something really terrible for me to go through the hell of the legal system. I mean I know other people who have had that experience, and I would encourage them to go through the legal system .. But I wouldn’t have the utmost faith in it, because you’re mentally ill, then you’re a crazy person.”

Therefore, due to competency issues, for Max and Rachel, the legal system was only reserved for the utmost, severe, and uncomplicated cases/disputes. Otherwise, both Max and Rachel said they would rely on or resort to other means to solve disputes, such as relying on the doctor and psychiatrists’ sense of responsibility to their patients.

Lastly, Roxanne stated patients rights had value only when someone had competence. For Roxanne, having competence meant having the ability to perceive and understand rights and her situation, and also having the ability to exercise rights. She stated that, as of now, mental health patients without competence needed better representation and better laws to mobilize:

“So I think that sometimes people need to have better representation ... like there are social workers for them, but the social workers are just going to go along with the psychiatrist, they’re not going to really go along with people who they think are crazy. And I don’t like using the word crazy, but that’s what what they think.”

For Roxanne, competency was self-defined, and she defined competency. as having a certain level of mental and educational abilities.

Overall, mental health patients were also more likely to see the legal system as an ineffective way to address their wrongs, due to matters of competency, and tended to reserve the

legal system for only extreme measures. Patients rights had realistic value and potential to those who saw themselves as competent (while for those who did not, patients rights had more theoretical, hypothetical, or symbolic value). Moreover, mental health patients who saw themselves as competent (Josh and Roxanne) also saw themselves as capable agents of the law. Without competence, or without the help of trusted representers, the structure of the legal system was described as an unfavorable or even hopeless means of seeking remedies for mental health patients.

POWER

I anticipated in my proposal that power will be a barrier to mobilization, primarily due to the unequal power relationships between physicians and patients. My findings revealed that power did play an important role in both the legal consciousness and mobilization of mental health sufferers. Power, however, played a much more complex role than merely serving as a barrier for patients against their physicians.

Power and Authority in the Hospital:

The Distant Doctor

Contrary to my primary assumption, the doctor was not the primary authority figure in the mental health sufferers' lives. The doctor still had enormous influence and power over the mental health patients lives. However, the doctor's distance also created deficits in his authority and power. All interview subjects who experienced involuntary hospitalization found the doctor to be quite absent from their hospitalization experience. As Alice noted, "The psychiatrist was really distant because he was pretty much the only psychiatrist. So he was just trying to go through as many people as he could and trying to figure out everything". Rachel, moreover, made a similar comment, "Well, I mean, the only people you can really talk to are nurses and then you get to see the doctor for like 10 or 15 minutes. I mean, they don't, they don't care. They're generally contracted out, and just come in and look at your meds".

The doctors and psychiatrists were also described as distant, cold, and unsympathetic to their conditions. Moreover, in comparison to the other authority figures at the hospital, they received the most unfavorable reviews from mental health patients in terms of procedural justice, which led to undermining the doctor's authority:

“I've had some great nurses in the psyche ward ... every psychiatrist I've seen in the psyche ward could give a f#\$@. And yeah, of course any kind of social worker or therapist is always really kind, and nutritionists are really kind. PhDs are generally really kind, but the MDs are generally the worst ... ” (Rachel).

Moreover, Elaine commented, “It's like, do you realize you [the doctor] have the power to change my life, for better or for worse? And for you to just write it off and say, ‘Oh, here, pop a few pills. It might make you feel better, it might not. I don't know’” (Elaine).

Despite the doctor's relative absence, however, the doctor still held enormous power over mental health patients lives because they had the capacity to admit or release patients and prescribe medications. As Max noted:

“With the doctor it was some nebulous idea of a person who showed up every so often and they just gave you meds. And so he didn't seem to have much authority, he didn't do much either, he had the authority to chose meds, and usually you didn't get input into that. They actually changed my meds a couple of times while I was there, and I didn't know why”.

In addition, despite holding power over patients lives, the doctor's distance became problematic to his or her legitimacy and authority for patients because it interfered with treatment. For example, many interview saw problems with the psychiatrist prescribing their medication, including Roxanne who stated:

“I didn't particularly like the psychiatrists because he wanted to stuff me with drugs, and he didn't really know me that well. [laughs] I would have preferred my psychiatrists, that

I had known before to give me drugs, instead of the ones at the hospital, or at least for the one at the hospital to talk to my psychiatrist. I don't think he did very well communicating, because he gave me a drug that I had before that made me very sick. So I didn't think he did a very good job".

Furthermore, in the short sessions given with the doctor, many interview subjects said they felt pressured to make a good impression on the doctor if they wanted to be released from the hospital. Alice said that she told the doctor that she felt better than she actually was in order to be released from the hospital. In this way, the sessions with doctors became more superficial and less treatment focused.

Overall, the doctor, despite having enormous power over patients' lives, the distance created deficits to his or her authority. The doctor's distance also created superficial relationships with his patients and also eroded the patient's confidence in both the doctor and their treatment.

Other Authority Figures

Aside from the doctor, other identified authority figures identified during the interviews included, nurses, security guards, social workers, staff members, group session leaders, academics, nutritionists, and medical students. For most patients, interactions between nurses and security guards made up their primary interactions in the hospital, aside from interactions with other patients. Their increased presence in the patients lives meant that they also had influence and power over patients lives. Max described the nurses and the guards as having enormous amounts of power and control over patients lives:

"You've got your nurses, with respect to them, you do what they say, if you don't they could do things to you. I mean, if you don't respond, or do something, it's pretty clear that they could make you do it, up to various laws. There are laws in place, but they could shoot you up with Risperidone, and you'll be quiet. It's not hard to silence somebody

with those kinds of drugs ... the guards and the nurses, you just did what they said, or things were not going to end well” (Max).

The nurses and guards yielded much power in the mental health patient’s experiences, because without the doctor’s presence, they were primarily responsible for both caring and controlling mental health patients on a daily basis.

In many ways, they were the true repeat players in the hospital setting, because they were more “on the ground” and was thus more familiar with how laws and rules operated within the hospital setting. As repeat players, they had more advantage in shaping how laws were implemented on the ground. For example, the nurse, by law, was suppose to inform Max of the option to be either voluntarily or involuntarily hospitalized for his mental illness. Instead, she strongly pressured Max to go voluntarily by implying that he would face high medical bills and risk being sent to John George if were to be sent involuntarily. Thus, the guidelines for the LPS Act was carried out much differently than intended. (Welfare and Institutions Code 5250) Moreover, the doctor’s absence left them enormous discretionary power. Interview subjects reported cases of disparate and discretionary treatment from nurses and guards. For instance, Jessica reported a case when a patient inside the John George Psychiatric Pavilion was bribed with cigarette gum to modify his behavior. Likewise, mental health patients were constantly reliant on the nurses and guards to meet their daily needs, such a Rachel getting her inhaler for her asthma, and summoning doctors upon a patients request.

Subtle, Ambiguous Power Structures/ Impressions of Fear

Many of my interview subjects alluded to the ambiguous, unspoken, and subtle nature of power in the hospital setting, which often discouraged legal mobilization. Despite it’s ambiguous nature, it certainly existed. Max commented:

“I mean if you were in a grievance with them, there’s a certain power structure in a power in a hospital that aren’t really spoken, you just have people who are big and scary, and you have people that are doctors and they’re suppose to know what they are doing. And so I mean, they could always say, ‘Oh, you’re just depressed. Oh, you’re just this’, because you already are marked with a disability or disease, one that can affect your choice. So yeah, its A, hard to call, and B, easy to do”.

Fear also played a crucial role because it acted both as a barrier to legal mobilization and as a form of social control. Interview subjects generally reported how fearful they were of the hospital setting, and was under the impression that something horrible could happen to them if they were not in compliance. For example, Heather commented:

“I was signing off paperwork about how it was a lock down and in a place where my rights are taken away. And they were taking away my necklaces, shoelaces, and all that stuff, and I was like, Oh my God, am I going to be in here forever? Because you know, you watch those horror movies. And I looked outside, I looked outside the window and you just see patients, and they’re just kind of like, you just see that their mind isn’t in there and they’re just kind of walking up and down the hall way, and like just walking up and down the hallway, over and over again. And I was just like, What is this place? And I was just like really freaked out for like the first two days”.

Moreover, Max noted how fear regulated his experience:

“ And the guards and the nurses you just did what they said, or things were not going to end well.[Would they use force?]I don’t know. I mean, when you’re looking at a guy who’s big, has tattoos over his arms and just for me, I was like, I’m not going to mess with that guy. He’s going to hurt me. So at least my thought was, if I don’t do this, something bad is going to happen. Wether it’s force, from him, or from meds, something I don’t know, but I’m not going to bug him“.

The hospital environment, the authority roles, and mental health patient's marked status all created impressions of fear and potential threat of physical violence or loss of liberty. Mental health patients were likely to be discouraged from mobilizing under fear, because they did not want to "make waves" in a scary, unknown, and unpredictable environment.

Money and Mental Illness

Galanter's discussion of repeat players and one-shot players reveals a crucial fact that the legal system is designed to privilege those with resources, the "haves" more often than the "have nots." Mental health patients were acutely aware that class and money mattered when it came to mental health care. Roxanne, for instance, identified that those with insurance, such as herself, were able to receive treatment in hospitals. Those without insurance, however, were sent to holding cells where they wouldn't be able to hurt themselves or others. Hence, for Roxanne, because she had insurance, hospitals were a safe haven for whenever she felt suicidal, and did not have to fear being sent to horrible places like John George (a county psychiatric hospital).

Rachel's story also confirmed that those with insurance were able to afford better treatment and care in hospitals. Rachel said she got sent to John George due to a shortage of beds at Herrick Hospital. She identified her eighteen hour stay at John George to be the most horrifying experience of her life. Moreover, because Rachel came from an upper-middle class backgrounded, attended a prestigious high school, and had insurance, she recognized that she could afford better treatment, and was eventually able to get herself transferred to a better hospital:

"So basically, I had okay insurance, There was no reason for me to go to John George ... when they told me I was going to John George, I was really pissed. I knew I shouldn't be going there ... I mean I was like what is happening here [John George], I need to get out of here, like this is not healthy. It was probably the most traumatic experience of my life ... This is unbelievable. I went to Miramonte High School."

In short, those with power and resources (the “haves” such as Roxanne and Rachel) were able to afford treatment and better options. In addition, the “haves” were able to recognize the possibilities of better treatment. For example, because Rachel recognized her own status, she was able to advocate herself out of the county hospital and into one with better resources and treatment.

Reforms

Defining and assessing civil commitment standards remains a hot button issue in the intersection between mental health and law. Numerous books have been written by scholars, physicians, and lawyers about how to assess competency (Grisso 1998; Victoroff 1969). However, competency still remains controversial because, as Saks argues, any competency standard requires some sort of normative assessment. The debate also tries to reconcile between a physician’s paternalistic values and a lawyer’s commitment towards autonomy. In other words, how do we distinguish if a physician’s act is an act of genuine care of an act that infringes upon a patient’s liberty?

Though the paternalism and liberty debate was extensive in the literatures of scholars, lawyers, and physicians, interestingly, this debate was not present in the discourse of mental health patients themselves. Mental health patients, for the most part, acknowledged that receiving treatment meant relinquishing some of their liberty. Josh, for example, argued that:

“Doctors are in control; nurses are in control. You [the patient] have to surrender control, and that’s scary enough when you’re feeling good, but when you’re feeling weak and vulnerable it’s even scarier. I mean it’s like that primal thing, where you think, why would I want to do that? You just want to survive the situation ... So that’s the irony of it. You have to turn things over to somebody else, who is a professional, who can get you the help you need”.

Rachel similarly noted that having certain rights taken away from mental health patients made sense, and was not necessarily a matter of justice but safety:

“You know when you get a bunch of people who are not well in a place like that, there’s a bunch of, Oh we’re not being treated fairly, and this isn’t justice. But a lot of that comes from sickness, and so people start looking like, My rights! these aren’t my rights! Well, actually, you’re trying to leave the hospital and kill yourself, so you don’t really have a lot of rights. Like I understand why I didn’t have a ton of rights” (Rachel).

Thus, for mental health patients, there was an understanding that it is sometimes necessary to limit one’s liberty for the purposes of health and treatment.

Likewise, when I asked mental health patient’s opinions about LPS Act (the involuntary civil commitment law in CA), all interview subjects (including Jessica who argued that she had been mistakenly imprisoned under the law) acknowledged that the law is a kind of a necessary evil. Moreover, the law seemed more favorable in hindsight. As Roxanne commented:

“I think it saves people’s lives. I think it’s harsh, but it saves people’s lives. [laughs]. I mean, I know I understand that people get really mad. But afterwards, there are support groups. If you go to support groups, you will hear people say they are grateful to be alive because of that law. So I’m not going to lie that I’m not grateful”.

Others like Heather and Max mentioned that the law gave a sort of “cooling off” period for mental health sufferers who were not in their “normal” state. Some commented on the arbitrariness or inefficiency of three days, but for the most part, mental health sufferers did not have problems with the law itself, but rather *how* it was administered. For instance, Rachel saw police intervention as problematic because in her experience, police were poorly trained to deal with mental health care issues.

Conclusions and Reforms:

Importance of Procedural Justice and Dignity

The single most important discourse that came up in every interview was the discourse of procedural justice and dignity for mental health patients. Rather than the paternalism v. liberty dichotomy, mental health sufferers framed issues regarding involuntary civil commitment as matters of procedural justice and dignity. Of course, mental health sufferers did acknowledge the troubling nature of assessing competency, and the potential for physician's abuse of a patient's liberty. But most added that there just wasn't much you could do about such situations, and there weren't very good answers to these deep theoretical questions. Though justice and liberty did matter, what was more important for mental health patients was receiving treatment in a dignified, humane manner. Moreover, despite their status as a mental health patient, or even as a perceived "crazy person," they desired to be treated like "normal human beings" whose subjective opinions mattered. Many patients stated that they respected and trusted figures who treated them like just any other human being and listened to their thoughts and concerns.

Mental health patients discourse reflected an emphasis in how they were treated more than anything else. For example, Elaine said she had a more difficult experience in her voluntary hospitalization experience rather than her involuntary hospitalization because of the way she was treated. She stated, "I hated the outpatient. It was voluntary, yet they pushed me, and it didn't feel voluntary anymore. Just the way they wanted me to do things, and I felt constantly pressured to do things I didn't want to do. And yet it's voluntary?". Hence, Elaine's comments expressed that there was an importance of how you were treated, rather than what kind of treatment you got (voluntary or involuntary).

In terms of her involuntary hospitalization experience, Elaine also said she understood why the doctors had to hold her against her desire to return home, but she wished they would "handle [the situation] in a more delicate manner." She also added that she respected doctors who handled situations more delicately. She added:

“I mean some doctors, they treat you like, you’re crazy, which I get it, like we are a little bit crazy. But other doctors actually treat you like a human being ... there were doctors, or even just staff at the hospital who were very kind. They were the ones who would bring me extra blankets because they noticed I was cold, or because they’d have to wake you up at certain times, the middle of the night, to take your stats and stuff like that or, give your medication at like 2 A.M. And some doctors would just turn on the light, and shove the dixie cup in your face and be like, ‘Take it.’ And other doctors would, you know first leave the light off, kinda pat you gently and be like, ‘Hey, I’m going to turn on the light because I have to give you your medication.’ I mean, that was like a lot better. I mean that’s like humane”.

Moreover, a big part of why Rachel saw her hospitalization at John George to be problematic had to do with how she was treated there, not necessarily that she was sent to a psychiatric hospital. Rachel stated:

“They take everything, and the [hospital gown] was too big, so I had to hold it so I wouldn’t be exposed. The whole time I had to just hold it. ... There were nursing students in there, just these young, and they were just sitting there looking at us like we’re bunch of freaks... And I basically was there for like 18 hours, and I just stood the whole time because there was no where to lie down, and so I was just standing holding this thing over me, so it didn’t open. And it was freezing and there was no... like no one cared. It was unbelievable” .

In Rachel’s experience reflected a sense that she was not treated as a full human being. Jessica also stated that during her hospital stay at John George that she “didn’t feel like, [she] had a place as a human being.” She added, “I felt like my position was to be a crazy person under their control to watch, and whatever they said, I had to do. I didn’t feel like I had say so in anything.”

In short, mental health patients I interviewed reflected a strong desire to be treated as normal, human being, despite being marked with a mental disability. Being treated fairly and in a dignified manner was a more important concern for mental health patients rather than the issues of involuntary confinement, liberty, and rights. Thus, Palley et al's suggestions for dignity based reforms matched well with what my interview subjects' desires and wishes. They simply wanted to receive treatment for their mental disorders in a dignified manner. Issues of liberty were not as important as the issues of dignity and procedural justice in the perceptions and experiences of mental health sufferers.

Lastly, in many ways, mental health sufferers' barriers to legal mobilization such as competency had ties to issues of procedural justice and dignity. Many were discouraged from mobilizing the law because they had experienced an eroded sense of dignity. Hence, dignity based reforms and higher levels of procedural justice would also encourage and give mental health suffers the self-esteem to address instances of mistreatment, humiliations, and wrongs more firmly.

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