

From the “Magna Carta” to “Dying in the Streets”: Media Framings of Mental Health Law in California

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Abstract

This article analyzes 575 newspaper articles across 53 years of reporting on California’s landmark 1967 Lanterman-Petris-Short (LPS) Act to examine framings of the challenges people with severe mental illness pose to the social order and shifting responses to them. The LPS Act restricted involuntary hospitalization which in the 1960s made it a “Magna Carta” that heralded a “mental health revolution” of voluntary, community-based care. Subsequently, coverage passed between four other framings that linked together different attributions of problems—like homelessness or suicide—with perceived flaws of the Act—such as encouraging the closure of hospitals or imposing barriers to forced treatment. Although previous research has focused on how the media amplifies fears of violence, this article shows how this framing is giving way to one focused on mentally ill people “dying in the streets” and the need for re-institutionalization to save them. By comparing media representations with other documentation from each period, this article demonstrates how these frames have continuously misattributed the consequences of complex policy and social changes to the granting of civil rights by the LPS Act.

Keywords

mental illness, civil commitment, Lanterman-Petris-Short Act, de-institutionalization, California, media, stigma

“Madness,” Andrew T. Scull (2015:10, 11) argues, is “indelibly part of civilization” yet poses “profound challenges of both a practical and symbolic sort to the social fabric.” Michel Foucault (1964) famously asserted that a “great confinement” in the seventeenth century was society’s response to the challenge of unreasonable people in an epoch that celebrated enlightened rationality. In the 1960s, “labeling” theorists offered a different grand narrative: that involuntary “civil commitments” to psychiatric hospitals were being used to manage deviants who escaped other systems of social control (Goffman 1961; Scheff 1999). While these authors all suggest that people with mental illness¹ are constructed as a social problem by society, we know less about how these

constructions change over time in response to specific policy developments.

This article uses newspaper discourse about California’s Lanterman-Petris-Short (LPS) Act to hold a mirror up to shifting representations of what should be done to and for people with severe mental illness. When the law passed in 1967, advocates hailed it as the “Magna Carta” for the

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mentally ill thanks to the strict new limits it placed on forced psychiatric treatment (Nelson 1967:A1). Over 50 years later, the letter of the law—which requires that people be a “danger to themselves or others” or “gravely disabled” to be hospitalized against their will—has changed little. Yet, concerns have flipped from worries that people were being unnecessarily incarcerated to fears that they are not being interned enough. LPS has become a “law that lets mentally ill choose to stay on streets” (Knight 2017) by allowing them to refuse treatment except in a narrowly defined set of circumstances. According to some commentators, it has among its effects “discrimination . . . increasing neglect, filling the jails, increasing suicides, homelessness, victimization, violence, hospitalization and untimely death” (Alexander 2015).

Although existing research has extensively documented how the media portrays people with mental illness as dangerous and culpable for acts of violence like mass shootings (Corrigan et al. 2005; McGinty et al. 2014), we know little about how claims about involuntary treatment specifically are filtered through the mass media. Moreover, studies focused on representations of dangerousness miss other social problems, like homelessness or drug use, that might be attributed to people living with mental illness. LPS is a strategic object for such an analysis. It has served as a “prototype for mental health laws in many other western countries” (Saya et al. 2019:2) that promote the civil rights of people living with mental illness. Yet, the law is also multivocal: it contained a variety of provisions that simultaneously created barriers to inpatient treatment while financing and encouraging outpatient care. It has thus become a canvas onto which the media and the advocates whose voices it amplifies can paint their shifting frustration with the mental health system and concerns about people with mental illness.

This article uses a mixture of structured and open coding of 575 newspaper articles to identify five frames dominating coverage of LPS at different times. “Frames” are cultural schema that call attention to specific aspects of a phenomenon, render them meaningful, and, in so doing, guide action in response (Goffman 1986; Snow, Rochford, et al. 1986). Frames of LPS provide an overarching linkage between particular aspects of the Act, a set of social problems that are culturally salient in a given time period, an interpretation

of why the bill is to blame for them, and an agenda of solutions.

First, at the end of the 1960s, stories emphasized how the problems posed by severe mental illness could be solved by a “Mental Health Revolution” of expanding voluntary community services. As the 1970s wore on, commentators fretted about how insufficient funding and poor conditions outside hospital walls were leaving patients abandoned in the “Cracks in Community Care.” In the 1980s, this frame ceded to a third one centered on how LPS sparked “Excessive Deinstitutionalization” that dumped people with mental illness onto the streets or into prisons. At the turn of the century, advocates evoked a hopeful future for people with mental illness by emphasizing scientific advances in treatment. Yet, the “Dangerous Brain Diseases” frame also relentlessly amplified homicides that they claimed could have been prevented if not for the LPS Act’s restrictions. This frame is today being overtaken by a new one that emphasizes that LPS leaves people with mental illness “Dying in the Streets.”

This article makes several contributions to our understanding of changing representations of mental illness. First, by comparing media coverage with other documentary sources from each time period, this article shows that the media has continuously *misattributed* the results of complex social and policy changes, like homelessness, to the LPS Act and the civil rights against forced treatment it granted. Second, these findings show transformations in who dominates public discourse about severe mental illness. Commentators have focused on how opportunistic politicians blame mental illness for mass shootings to divert attention from gun laws (Carey 2018). Yet, the frequent drivers of this marriage between fears of violence and calls for reform were advocates—most notably, family members—for the mentally ill themselves.

Finally, this article shows that, while research has centered on how media forge a linkage between mental illness and violence, the problems attributed to people with mental illness have shifted substantially over time. Some of these concerns seem distant today (like conditions in community boarding homes) while others (like drug use) are surprisingly absent until late in the study period. A new emphasis on self-harm leading homeless drug addicts to “die on the streets” is replacing the focus on harm to others and homicide identified by previous studies. “Beds” are

overtaking “meds” as the proposed solution. Whether these new media narratives will be followed by a broader shift in public opinion—and perhaps a new “great confinement” facilitated by reforms of LPS to match—is a subject for future research.

CULTURAL FRAMING: MENTAL ILLNESS, PUBLIC STIGMA, AND MEDIA REPRESENTATIONS

The mass media does not just neutrally depict the world but actively “frames” it in ways that affect both political agendas and public opinion. Erving Goffman (1986:21) developed the concept of “framing” to describe cognitive schema that help individuals “locate, perceive, identify, and label” experiences and events and thus render them meaningful. Since then, scholars have focused on how frames are a shared part of culture that help individuals interpret and thus respond to situations in coordinated ways (Wood et al. 2018). Research has shown how social movements, for example, use framing to help the public link problems in their own lives to broader political issues and encourage them to see participation in a specific movement as a way to address those problems (Snow, Rochford, et al. 1986).

The media, too, “frames” what happens in the world by selecting, emphasizing, and attaching meaning to certain elements of social problems (Benson and Saguy 2005; Gitlin 1981). Colin Jerolmack (2008), for example, studies how newspapers turned the somewhat banal presence of pigeons in cities into a problematic infestation of “rats with wings.” Studies have consistently shown that the media frequently associates mental illness with violence and danger (Corrigan et al. 2005; McGinty et al. 2016). Research focused specifically on gun violence has shown spikes in articles that link mass shootings to mental illness after events like Aurora and Sandy Hook, as the media searches for an interpretive frame to make sense of seemingly inexplicable acts (McGinty et al. 2014).

Why does media framing matter? First, scholars have argued that framing plays a core role in “agenda setting” by transforming certain social phenomena into public issues that demand attention from the public and policymakers (McCombs and Shaw 1993). For example, increasing coverage and morally charged framings have fueled

the widespread perception of an “obesity epidemic” for which people’s individual practices—not structural conditions—are responsible (Saguy and Gruys 2010). It has promoted “medicalization” rather than “criminalization” as a response to the opioid epidemic, in stark contrast to portrayals of crack cocaine as a criminal justice rather than public health problem (Shachar et al. 2020; Weiss and Zoorob 2021).

Second, and closely related, media framings shape public opinion. Sociological work in the 1960s argued that mass institutionalization was driven by how society “labeled” deviant behavior from socially dis-integrated individuals as “mental illness” (Goffman 1961; Scheff 1999). Since then, researchers have documented substantial shifts in how Americans understand this label. On one hand, the broader public increasingly roots mental illness in genetic or biological factors rather than moral failings (Pescosolido et al. 2010; Phelan et al. 2000). Yet, these shifts in understanding—which have been encouraged by public awareness campaigns—have not broken the “backbone” of stigma: a persisting desire for “social distance” from people with mental illness (Martin et al. 2007; Pescosolido et al. 2013). These studies show that there is rising support in the U.S. population for *involuntary* treatment of people increasingly seen as dangerous (Pescosolido, Manago, and Monahan 2019).

Both advocates for people with mental illness and scholars have assumed that the mass media is one key driver of these changes (Palpant et al. 2006; Scheff 1999; Wahl 1992) for well-founded reasons. Many Americans report that the mass media is their central source of information about health (Brodie et al. 2003; Clarke 2011). Experimental evidence demonstrates that articles in the media can increase negative attitudes toward people with mental illness and support for forced treatment (McGinty et al. 2018; Thornton and Wahl 1996).

Existing studies of media framing of mental illness are nonetheless limited. On one hand, many studies sample articles specifically examining the relationship between mental illness and dangerousness, violence, and crime. This tells us little about how these foci rise and fall relative to other possible concerns linked to mental illness. On the other hand, broader studies on representations of “mental health” in general do not have sufficient analytical focus or a long enough time horizon to address these gaps in narrower studies of mental

illness and violence. For example, Patrick W. Corrigan et al.'s (2005) expansive study only includes a small number of stories that discuss issues like involuntary treatment, homelessness, or institutionalization. Terms like "mental health" are so broad and enveloping (see Horwitz 2001) that they do not allow us to focus on "madness," or the "massive and lasting disturbances of reason, intellect, and emotion" (Scull 2015:11) usually associated with schizophrenia. In addition, studies that use exclusively quantitative coding schemes to identify the presence or absence of certain topics (like "drug use") are limited in what they can tell us about the deeper cultural meanings attached to mental illness through framing (Olstead 2002).

The LPS Act is a unique object for addressing some of these lacunae. The Act appeared early in the transition away from mass institutionalization, and thus discussions of it capture the headiest optimism about the process. Yet, the Act has also been enduring: alterations to it have been limited and media outlets still refer to it by name. By studying framings of LPS, we can examine how a single law has become the culprit for the constellation of concerns about a host of related developments, from de-institutionalization to community care to mass incarceration.

LPS is also a useful object for study because of its multiple provisions. It is now best known for the requirement that someone be a "danger to themselves or others" or "gravely disabled" to be hospitalized, as well as the time limits it places on involuntary commitments. But the bill also includes provisions about the financing, organization, and delivery of care, thus providing the media with ample material to either amplify or downplay. Indeed, this article shows that the media has picked up and promoted a new reform agenda also encouraged by politicians and psychiatrists (see, for example, Carey 2018; Sisti, Segal, and Emanuel 2015): the need to build more "beds" and not just prescribe more "meds."

DATA AND METHOD

This article uses newspaper articles from the NewsBank, ProQuest, and LexisUni databases, which include, respectively, the *San Francisco Chronicle*, *Los Angeles Times* (*LA Times*), and *San Diego Union-Tribune* from 1967, when the law was passed, to the end of 2020. From 1985

forward, these databases also include two other major papers in the state (*The Sacramento Bee* and *Orange County Register*) as well as dozens of smaller local outlets. The dataset includes nearly all articles from these papers that contained either "Lanterman-Petris-Short" or "LPS Act." It excludes a small number of articles that referenced LPS without giving any detail about it (such as an article discussing "Probate Conservatorships" for developmental disabilities that noted only that they were different from "LPS Conservatorships"). All told, the dataset includes 575 articles: 302 feature articles, 132 opinion pieces and editorials, and 141 letters. The number of articles per year ranges from 1 (in 1995) to 53 (in 1999).

The primary researcher read a small number of articles from each decade and used this to develop a 75-item coding grid that identified key topics discussed across articles: the objectives, consequences, and flaws of LPS, who was quoted speaking about LPS, and evaluations of the law. All variables were binary—whether or not the article mentioned a given topic (like "homelessness")—except for evaluations by speakers or authors, which were coded based on a 5-point Likert-type scale. The first researcher applied the grid to all 575 articles, while a second researcher coded a sample of 20 percent of articles using the same grid as a reliability check. The Cohen's kappa, the standard measure of reliability, was .95. This was substantially above the conventional standard for adequate reliability, .69 (Landis and Koch 1977).² Figures were produced in R using ggplot and show the smoothed proportion of articles mentioning a given topic by year.

Articles were simultaneously coded in the qualitative data analysis program *Dedoose* to analyze how concepts related to each other and cohered over time (Jerolmack 2008; Olstead 2002). Qualitative codes were applied to over 2,500 separate units of text across all 575 articles. The five framings identified were developed iteratively by identifying quantitative trends and using qualitative analysis to illustrate and interpret them. The representativity of the qualitative excerpts used to illustrate each time period is ensured by choosing quotes that are reflective of the quantitatively identified differences between time periods.

Mass media are a useful window into changing conceptions of public policies and social problems, because, as Abigail C. Saguy and Kjerstin Gruys (2010:235) argue, "once created, these texts

remain unchanged and available for analysis, making them ideal for the study of attitudes, concerns, ideologies, and power relations and how they shift over time.” The extent to which the framings identified by the researcher accurately captured the dominant discourses about LPS in different time periods was partly evaluated based on semistructured interviews with 120 policymakers, advocates, and clinicians in California. Yet, mass media do not necessarily accurately represent the reality they purport to describe. This article evaluates the degree to which these framings diverged from what was actually happening in California through these interviews and government reports, published and unpublished administrative data, and secondary literature.

There are important limitations to this methodological approach. Most longitudinal studies using newspaper articles draw on the same sources across the study period (Corrigan et al. 2005; McGinty et al. 2016). The quantitative trends are similar for a subset of articles from only the *San Diego Union*, *San Francisco Chronicle*, and *LA Times*. However, their coverage of LPS is sporadic, and in the last decades, other papers (like *The Sacramento Bee*) have moved to the forefront of discussions of reforms. Including more papers also gives a large enough sample to analyze rarer contributions, like letters written by people subject to commitment under LPS. A second limitation is that not all references to involuntary psychiatric care in California identify the LPS law specifically. Third, newspapers are not the only mass media influencing perceptions of mental illness, but I do not analyze radio and television here.

RESULTS: REFRAMING THE LPS ACT

The “Mental Health Revolution” (1960s)

What newspapers referred to as “one of the most revolutionary mental health bills ever” (Nelson 1970:1) originated in a study of commitments to state hospitals commissioned by the legislature in 1963. The report, released in 1966, cited “labeling theorists” (Goffman 1961; Scheff 1999) to argue that psychiatric expertise was unreliable and treatment often ineffectual. It lamented how the media had contributed to a “mad dog” stereotype of the

mentally ill in the “public’s mind” (Subcommittee on Mental Health 1966:17). It went on to argue that this stereotype was providing justification for long-term court-ordered institutionalization:

Despite the problems of definition, identification, and prediction; despite the questionable value of certain treatment programs; and despite the civil liberties problems, the general public, its elected representatives, and civil servants have perpetuated the commitment court and mental hospital system as a means of disposing of a variety of disagreeable social problems. (Subcommittee on Mental Health 1966:12)

The report provided recommendations that became the basis for the LPS Act, which passed nearly unanimously. Its preamble declared an objective of ending “the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders.”³ One article celebrated that it “restored” patients’ “basic, civil rights as human beings” (Flores 1970:29).

The frame of the 1960s and early 1970s was not just that this “Mental Health Revolution” offered a bill of rights *against* forced treatment, however, but also that it would *expand* access to voluntary care. As shown in Figure 1, over half of articles described the objectives of the bill as promoting community treatment and financing that treatment (through a provision for the state to pay 90 percent of the cost of county-run public mental health programs). The Act “would put the money where the patients are, not where the institutions are,” drawing on the finding from “modern psychiatry” that “treating the mentally ill early and in the community environment is often more effective” than hospital care (*LA Times* 1968:SF10). The head of the state Department of Mental Health (DMH) predicted it would “revolutionize the entire system of public health care in the state” (*LA Times* 1969:B1).

As Figure 1 shows, the protections against people being “railroaded” or “shoveled” (Boyarsky 1982:A1) into hospitals, which would ultimately come to dominate framings of LPS, appeared in only about a quarter of articles in the 1960s (Figure 1). Instead, the media identified the bill as having other impacts which would receive almost no attention in subsequent decades. By emphasizing modern, community-based care, the “Magna

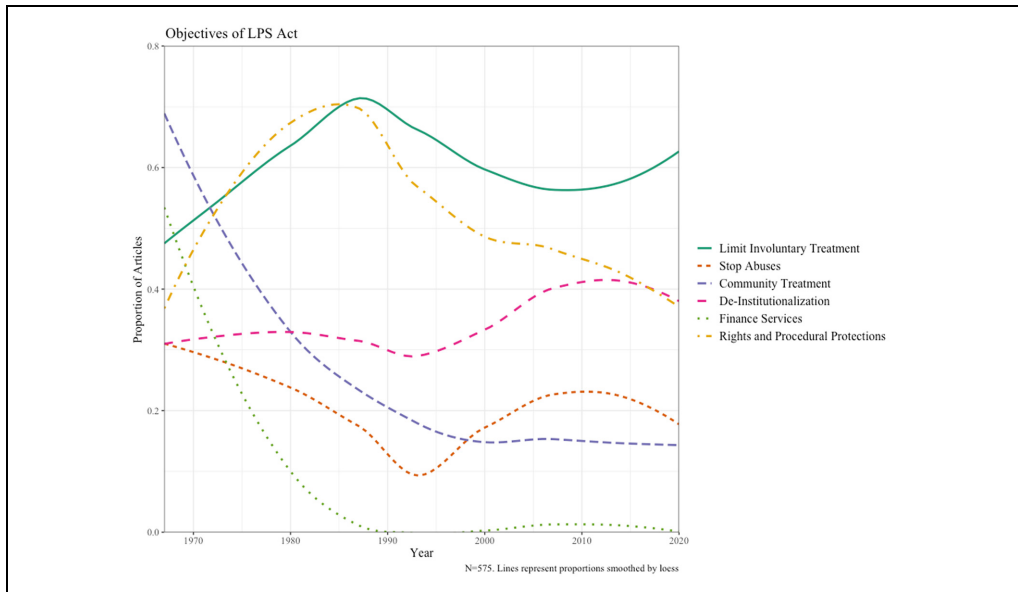


Figure 1. Objectives of Lanterman-Petris-Short Act.

Carta” would “go a long way toward ending the stigma of mental illness” (Nelson 1967:A1). Clinicians and Mental Health Department officials dominated discussions and saw the law as not so much blocking treatment as “encourage[ing] voluntary treatment,” including in inpatient settings (*San Diego Union* 1969:15).

Among LPS’ boosters was Governor Ronald Reagan, who in 1967 described LPS as “the most feasible and enlightened way to achieve the best results for treatment of our mentally ill” (Gilliam 1967:32). Reagan added that the bill had another purpose (which was not actually in the text itself). With “the development and expansion of local programs,” the state would be able to “reduce the size of our [public] mental hospitals.” In truth, California’s state hospitals—like state hospitals around the country—were already rapidly discharging patients before the bill went into effect (Legislative Analyst’s Office 2000), thanks primarily to the availability of federal funds (Medicaid and Supplemental Security Income) to pay for community but not state hospital care (Scully 1977). Still the earliest critiques of the bill came from hospital employees’ unions who blamed it for impending closures. The Director of DMH responded,

California has an absolutely outstanding system . . . It’s a leader in the nation;

a leader in the world, and for a group of employees to say we should go back to the snake pits and the warehousing of patients in large impersonalized institutions I find hard to believe, let alone accept. (*San Diego Union* 1972:5)

At this point, coverage framed this criticism of revolution as backward-looking and reactionary.

Falling into the “Cracks in Community Care” (1970s)

By the mid-1970s, however, concerns about financing, services, and government interest in the system created by LPS congealed into a frame centered on patients’ abandonment into the “Cracks in the Community.” Media focused on the failure of the state to deliver the two things—community care and financing for it—it had previously presented as at the core of LPS. A 1972 editorial in the *LA Times* opined,

In recent months . . . there has been growing concern that the money saved has not been following the released patients back to their communities as envisioned in the [LPS] Act . . . and that the patients are not getting the type of care they need . . . The governor’s

proposed budget would “shortchange” the mentally ill by using money saved in state hospitals for other purposes. (Editorial Board 1972:F2)

But even critical takes were carefully circumscribed:

Most psychiatrists and mental health leaders are in basic agreement with LPS, believing that mental health care is best handled close to home. Hospitalization and isolation of mental patients . . . has done little to rehabilitate them and modern treatment has, in most cases, eliminated the necessity for long-term residential care. (Barber 1972:SE1)

In short, the author summarized, “it is not the philosophy they argue with but the methods, and most of all financing” (Barber 1972:SE1).

By the mid-1970s, concerns about the consequences of LPS were intensifying. Coverage trained more attention on the barriers the law posed to involuntary treatment, particularly for people who might be suicidal (a focus that would later be overtaken by concern for those dangerous to *others*). The *San Francisco Chronicle* in September 1975 encapsulated this fear:

The plight of a 20-year-old San Leandro man who three times in as many months tried unsuccessfully to commit suicide from San Francisco hotels has brought into focus the terrible dilemma confronting psychiatrists and civil libertarians. Young [name] is a patient under psychiatric care at Oakland’s Highland Hospital . . . The question now is how soon will psychiatrists treating him decide that he no longer is a danger to himself or to others . . . Under the [LPS] Act (known as the Bill of Rights for the mentally ill) an individual can be detained only if he is a danger to himself or to others. (Anspacher 1975:5)

The article lamented that “too great an emphasis is now being placed on the civil rights of mental patients and too little on their emotional ills,” quoting a psychiatrist who sounded the alarm that “we’re liberating troubled kids before we have a chance to heal them.” A finding from the first major evaluation of the law—that time limits on treatment for patients deemed a “danger to

self” had “not increased the rate of violence or suicide . . . in comparison with pre-LPS rates” (Urmer 1975:252)—received comparatively little attention (cf. Nelson 1973:A1).

Papers also targeted insalubrious conditions in a new system of underfunded private institutions that sprouted up in the cracks of the safety net. While the state was failing to provide the funds promised by LPS, “Board and Care” homes were harvesting the checks that people with psychiatric disabilities started receiving with the introduction of Federal Supplemental Security Income in 1971. One psychiatrist lamented, “what we have are a series of poorly-staffed, poorly-equipped miniature mental hospitals” feeding into a system in which, according to one clinic director, “there are many, many people who fall through the cracks” (Shuit 1972:A1). A 1978 opinion piece from a Congressman declared that patients were “end[ing] up in dilapidated hotels and boarding houses in slum areas, out of society’s sight and mind” (Pepper 1978:D5). He went on to declare that while California was a leader when it “advocated dehospitalizing patients as a matter of policy,” that move now looked more like a harbinger of a “national scandal.”

Yet reporters as well as the clinicians and politicians they quoted continued to describe LPS as a “revolution.” Even when discussing the law’s downsides—people left untreated or languishing in poor quality housing—they embedded their critiques in praise for the law’s general aim. For example, in 1972 the *LA Times* commended “clean-up” bills introduced by Assemblyman Frank Lanterman, one of the bill’s original authors, aimed at “improving aftercare services” and “establishing a system to monitor effectiveness of local programs” (Editorial Board 1972:F2). They cautioned against returning to a not-too-distant past where people were abandoned, instead, in state hospitals. The “Cracks in Community Care” frame presented the problem as one of implementation and the solution as plugging these cracks with enhanced services.

“Excessive De-institutionalization” into Streets and Jails (1980s–1990s)

By the end of the 1970s, articles were using a new label for an ongoing “exodus” from “public institutions” like state hospitals: “de-institutionalization” (Graham 1977:2). Even though

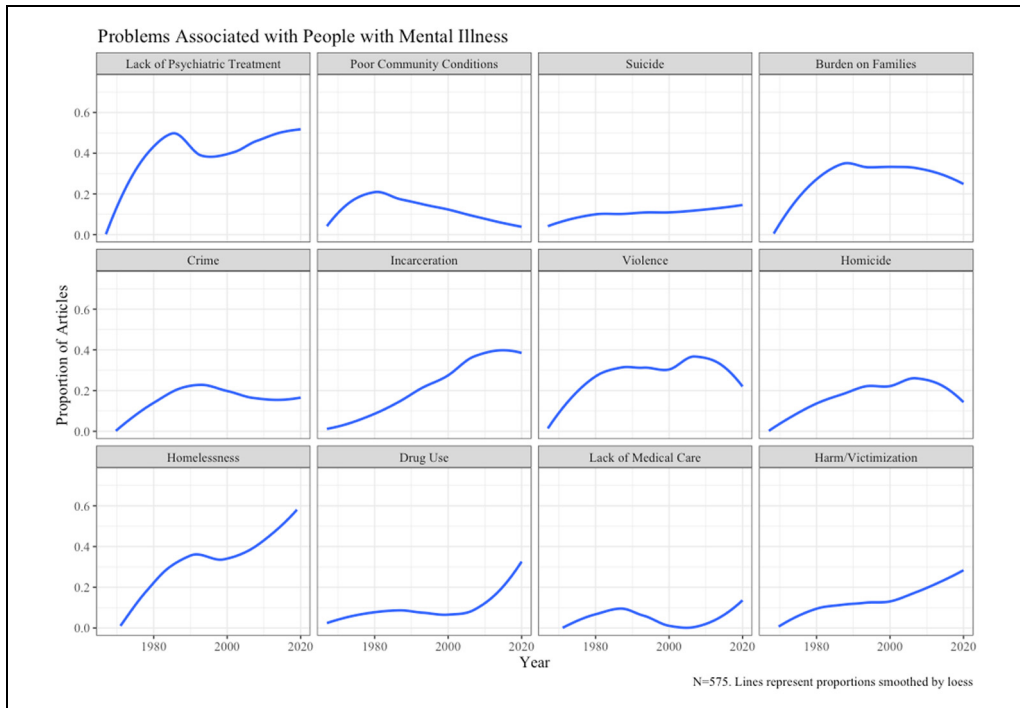


Figure 2. Problems associated with people with mental illness.

the closure of nine of California's 14 state hospitals did not originate in the letter of the law, the media increasingly portrayed de-institutionalization as one of the law's central aims (Figure 1). In this new framing, concerns about increasing homelessness, mass incarceration of people with mental illness, and a rising burden these individuals imposed on their families largely displaced the previous focus on poor quality community care (Figure 2).

Discussions of de-institutionalization extended the "Cracks in the Community" frame's emphasis on underfunding and insufficient government engagement, but turned more sharply negative. In a front-page story in 1985, *The Sacramento Bee* quoted Bruce Bronzan, an Assemblyman holding hearings on LPS. He "flar[ed] into anger" as he declared,

Do you realize nobody is responsible for those people? . . . The most desperate people in our whole society, people with ravaging, chronic, serious mental illnesses, who are on the streets and cold and have no food and no place to sleep . . . The state

has completely turned its back on this group. (Gray 1985:A1)

A federal report from this period concurred that community care services were not only underfunded but also placed a low priority on serving former state hospital patients vis-à-vis people with lighter pathologies (Steering Committee on the Chronically Mentally Ill 1980).

But this new frame identified new problematic consequences of the law. If in the 1970s former hospital patients were slowly and invisibly wasting away in decrepit Board and Care homes, now they were rapidly and visibly deteriorating in the street. A 1982 article in the *LA Times* offered a simple explanation: "Why are there so many mentally ill people on the streets, shambling hopelessly through downtowns when, in an earlier time, they would have been locked up in mental hospitals?" (Boyarsky 1982:A1). One issue, the article noted, was "cost-cutting . . . by budget-balancing state officials," but funding for services was "only part of the puzzle." The LPS Act struck a new balance on the "fundamental question of the

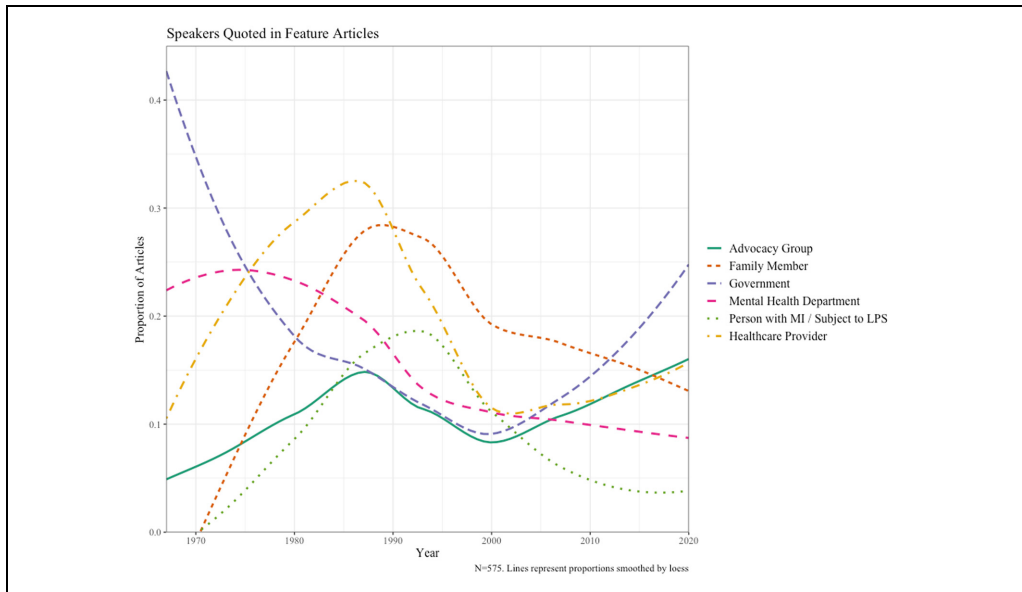


Figure 3. Speakers quoted in feature articles.

Note. LPS = Lanterman-Petris-Short.

right of society to protect itself versus the right of an individual to be free” that favored the latter to such an extent that it became “all but impossible to force treatment.” The “Excessive Deinstitutionalization” frame pinned homelessness on the procedural protections of LPS. It glossed over that, while some evidence suggested cities that closed public hospitals saw larger increases in homelessness (Markowitz 2006), former state hospital patients were a small part of an unhoused population forming as a result of broader economic changes and cuts to social welfare (Snow, Baker, et al. 1986).

Some of the most forceful arguments that the pendulum had swung too far toward civil liberties came from self-identified family members of people with mental illness. In 1986, the *LA Times* published an anonymous letter under the headline “Plea for a son who can’t get help” (Anonymous 1986:12). The author described schizophrenia as “such a devastating, all-encompassing problem that no one weapon can conquer it.” But, she noted,

We have no weapons at all because of the [LPS] Act. My son is not a “danger” to himself, not a “danger” to others, and he can still get a fork to his mouth, so we are legally not able to get him the

hospitalization he so desperately needs. So, we’ll go on, and on, and on, subjecting him to more humiliation and needless agony. . . Each trip to jail pushes him further . . . into the Dante-like inferno, makes his rehabilitation just a little less possible.

In her letter, she addressed the “Orange County judges” who had previously released him from the hospital: “His dignity as a human being has been stripped from him, and he is being treated inhumanely under the guise of protecting his ‘rights.’” Over 90 percent of statements from parents offered either a critique of LPS or support for expanding involuntary treatment. By 1990, family members had overtaken clinicians, mental health departments, and government officials as the most frequently quoted constituency (Figure 3).⁴

These articles suggested an agenda centered not on expanding services but rolling back procedural protections, which was the intention of a reform bill proposed in 1987. This move to curtail “excess” rights, however, ran into opposition from people who were happy to exercise them. Media coverage was generally favorable to reform, but in these articles the voices of people identified as once- or current-mental health “clients” began to appear for the first time. Their appearance mirrored the rise of a “consumer/survivor/ex-patient”

movement nationally (McLean 1995). They contributed to the framing's emphasis on LPS as a civil rights bill and not one focused on promoting community care, even as they argued that LPS did not go far *enough* in protecting them. The *San Jose Mercury* recounted the tale of a man hospitalized by his parents: "The psychiatrist told him he needed drugs, [he refused]. So hospital staffers surrounded him, pulled him down, and injected him with a powerful anti-psychotic" (O'Brian 1988:1L). The experience pushed him to become "active in the burgeoning mental patients' rights movement": as he explained, "When you are forcibly drugged, it's a violation of the sanctity of your body. You really feel humiliated . . . We see it as a civil rights issue, a basic issue of dignity and humanity." Resistance to reforms was aided by the fact that rights were cheaper to guarantee than welfare. One article quoted "state officials" who noted, "By lengthening confinement, the . . . bill would require more beds in state mental hospitals, boosting state expenditures for the budget-conscious administration" (Boyarsky 1987:A1). The bill went down to defeat.

As the 1990s wore on, stories shifted toward a new kind of *trans-institutionalization* facilitated by LPS. As the *LA Times* reported,

The largest mental institution in the United States rises from a bleak industrial sector of downtown Los Angeles, a maze of concrete walls and steel bars where more than 3,000 people with mental illnesses are crowded into dimly lit cells. The "mental institution" is, in fact, Los Angeles County Jail . . . The jail has become a vast holding tank . . . a "hospital of last resort" for psychotics and others cast adrift by the county's rapidly disappearing community mental health system. (Tobar 1991:1)

Despite this reference to ongoing cuts to outpatient mental health services, the article focused on a now-familiar culprit: "The 1967 [LPS] Act . . . emptied California's mental hospitals . . . A quarter century after . . . jails have become a dumping ground for the mentally ill." These articles paid minimal attention to the fact that the elderly, white population of state hospitals pre-LPS looked little like the younger and darker skinned individuals crowding prisons (Raphael and Stoll 2013).

Ultimately, the frame suggested that patients' rights did not so much get them out of institutions

as allow them to cycle endlessly between jails, hospitals, and shelters. The conclusion was that, as a 2001 editorial in the *San Diego Union-Tribune* put it, "California's attempt to deinstitutionalize mentally ill patients" through the LPS Act was a "callous mistake" that "left thousands of severely troubled people in their own personal hell" (Editorial Board 2001:B8). Articles grossly oversimplified the political, social, and economic origins of homelessness and mass incarceration. They presented reforms that would curb rights to allow more forced hospitalization as a way to help people with mental illness escape both.

Medicating "Dangerous Brain Diseases" (1990s–2000s)

In 1991, a woman named Carla Jacobs wrote to the *LA Times* to recount her experience with "tighter and tighter interpretations of the [LPS] Act, under which a neuro-biologically disordered (mentally ill) victim cannot be involuntarily treated until he becomes an immediate danger to himself or others." This was too strict for her sister-in-law, who for two years was living on the streets (feeding herself "frequently out of dumpsters") and refusing treatment. Then, without explanation, Jacobs' sister-in-law went home and "shot the bullet which murdered her 78-year-old mother" (Jacobs 1991:6). Jacobs was certainly not the first to allege that people with severe mental illness were potentially violent. In 1973, that same paper reported on "109 murders . . . committed in less than two years by 22 former mental patients" (*LA Times* 1973:C6). But back then the editorial board concluded that these figures, "alarming as they are, do not reflect negatively on the state's progressive program for treating mental patients in their home communities under the [LPS] Act."

Jacobs, however, was insisting on a new framing, "Dangerous Brain Diseases," which became dominant in the late 1990s. Psychiatry had advanced in its understanding of "neurobiological" disorders since the 1960s. This meant the LPS Act was, as one psychiatrist wrote in an editorial, "based on outdated, non-scientific ideas, not on current scientific studies" (Fuller and Zdanowicz 1999:9). In the eyes of advocates for reform, the archaic law failed to recognize:

. . . the inability [of people with mental illness] to realize they are ill and need

medication . . . Families of the mentally ill . . . have seen and heard about the denial syndrome many times. During an interview at their Seal Beach duplex, Roger, a retired computer salesman, reaches into his shirt pocket and pulls out a 3-by-5-inch notecard. In capital letters, he carefully prints the word “ANOSOGNOSIA”—defined as a patient’s inability to recognize his or her own disorder or illness . . . “It’s the Catch-22 that the authors of the LPS Act didn’t take into account.” (Teetor 2002:18)

Neil Gong (2017) points out the complex reasons why people might refuse medication, including side effects, a failure of clinicians to engage with and educate their clients, or a lack of supports in the community that would allow people to access and store prescriptions. Still, this new frame allowed the media to simplify treatment refusal as a disordered symptom of illnesses themselves. This rejection of medication:

. . . had some validity in the ’60s, when some psychiatric hospitals overused debilitating antipsychotic drugs like Thorazine to subdue patients. Today, however, those drugs have been replaced by effective medications with few adverse side effects that greatly enhance patients’ ability to make rational decisions. (Editorial Board 2000b:8)

The implication of this framing was clear: “we need to abolish or amend the LPS law because treatment works” (Payne 1998:B9).

There was another side to critiques of LPS in this period: brain diseases were treatable, but left untreated, they were threatening. As Figure 2 shows, discussions of violence, risk, and homicide tied to people with mental illness peaked in the early 2000s. One paper reported that critics in the 1970s who argued that “the impact of the [de-institutionalization] movement on society could be dangerous” were “brushed aside” (Teetor 2002:18). The result was that “mental patients released into their communities commit nearly 1,000 homicides each year.” The examples cited by the media were both specific and scary. In 1999, the *Santa Rosa Press Democrat* published an opinion piece from an author who described how California’s “misguided attempt to protect” his brother’s “individual rights and human dignity” meant hospitals “[kept] sending him back

out.” He then used his disability check to “buy an AK-47 and several pistols,” after which he “went into an elementary school in Stockton, where he murdered five kids, then killed himself” (Cramer 1999:G1). Another described a woman for whom police “never saw fit to seek a three-day hold in a psychiatric hospital.” She later “drowned her children and herself” (Marquis and Morain 1999:A1).

These stories suggested that people with severe mental illness were not a small, identifiable population in the streets or boarding homes, but all around in society, invisible and waiting to snap. Those seeking reform rarely pushed back against sensationalist stories. In 1999, Assemblywoman Helen Thompson, a Democrat from Davis and former psychiatric nurse, proposed a suite of changes to LPS that would facilitate and fund involuntary care. When a former state hospital patient “drove [an] 18-wheel semi-truck laden with canned milk up the steps into the south entrance of the 127-year-old [California] Capitol” and “died in the resulting fire,” she described it as a “wake-up call for reform” (Tamaki 2001:A3). Articles rarely mentioned that because violence among people with mental illness is rare and difficult to predict, large numbers of people would have to be committed for long periods of time to impact rates of it (Glied and Frank 2014).

Although they were almost entirely absent from a deluge of opinion pieces, letters, and editorials in favor of reform, defenders of LPS “jammed the hearing room” where the legislation was being discussed “and testified that there is no need to change” the law (which, the journalist editorialized, “makes it all but impossible to force the mentally ill into treatment”; Morain 1999:3). Former patients who had been “involuntarily hospitalized, placed in restraints, misdiagnosed and drugged repeatedly against their wills” evoked “constitutional protections.” “Give me liberty or give me death” declared the executive director of the California Network of Mental Health Clients (Marquis and Morain 1999:A1).⁵ Two attempts to overhaul LPS fell apart in 1999 and 2000, despite passing the assembly overwhelmingly. John Burton, a San Francisco Democrat who was president of the state senate, declared that the bills were “coercive” and—in something of a throwback to the 1970s—joined patients’ rights groups in arguing that the problem was “inadequate funding of community health programs” (Editorial Board 2000a:B10).

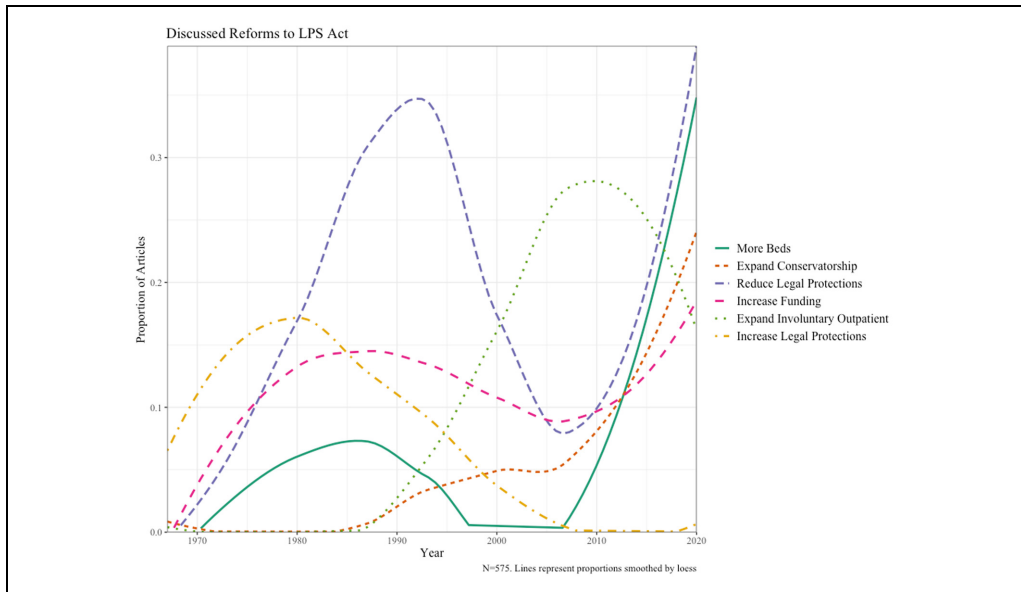


Figure 4. Discussed reforms to Lanterman-Petris-Short Act.

The next year, Thompson offered a stripped-down bill to create a new program, “Assisted Outpatient Treatment” (AoT), which came to dominate discussions of reform (see Figure 4). AoT would allow judges to obligate patients with a history of hospitalizations to accept outpatient care, an approach that had already been used for two decades in states like North Carolina (Scheid-Cook 1993). Stories frequently mentioned that the bill was named “Laura’s Law” after 19-year-old Laura Wilcox. She was killed in the clinic where she was volunteering by a person living with schizophrenia who was allegedly not taking medication (Rizo 2002).

The study the legislature commissioned found that there was little evidence that adding a court mandate through AoT would lead to better outcomes versus intensive voluntary outpatient services (Ridgely, Borum, and Petrila 2001). But “Laura’s Law,” which passed in 2002, nonetheless responded to much that was central to media framings in the late 1990s and early 2000s. Because of LPS, a police chief observed, the system could do nothing for people who are “too sick to know that they are sick” (Rizo 2002). By using the courts to compel medication compliance (rather than hospitalization), AoT focused on delivering the advanced treatment that might free some of those mentally ill from their dangerous brain diseases.

Re-institutionalizing Those “Dying in the Streets” (2010s)

In 2020, Governor Gavin Newsom devoted his entire “State of the State” speech to a single issue: homelessness. Although he announced a basket of initiatives to stabilize rents, build new housing, and expand shelters, he also promised a “laser-focus” on “getting the mentally ill out of tents and into treatment” (Newsom 2020). Current laws set the “threshold for [involuntary treatment] too high and need to be revisited” to account for people who are “tragically” not “capable of accepting help.” Newsom’s speech captured the main themes of the “Dying in the Streets” frame that came to the fore around 2017. The homelessness to which LPS contributed was not just an eyesore but a source of suffering and death. Forced treatment was a progressive act of compassion, not an attempt to protect society from dangerous madmen. Unlike the pushes for reform in the 2000s, Newsom insisted that loosening the criteria for forced care would be an “empty promise without creating more placements,” particularly in locked facilities.

By 2016, the vast majority of articles mentioning LPS discussed homelessness (Figure 2). Moreover, as time wore on, this chronic problem took on a new, acute urgency. In 2008, Newsom, then

Mayor of San Francisco, told the Chronicle that “a lot of these [homeless] people are literally sentenced to death” (Nevius 2008:B1) by barriers to involuntary treatment.⁶ Newsom’s primacy in pushing this framing was emblematic of the shift from families to government officials as the dominant voice in media coverage (Figure 3). Toward the end of the next decade, papers reported statistics like the following:

In 2017, more than 800 homeless people died in L.A. County from medical conditions that are considered to be preventable, records show. There is no estimating who among these were mentally ill, but it is acknowledged that mentally ill people are least likely to perceive how dangerous and unhealthy their living environments are. (Curwen 2018)

“Individuals are falling through the cracks,” explained a deputy for Los Angeles County Supervisor Kathryn Barger, but now the consequences were more existential than just poor living conditions (as in the 1970s).

Although the link between death on the sidewalks and untreated mental illness was only a correlation, reporters anchored their articles with stories like that of a homeless man in Stanislaus County that made the connection clear:

His mental state deteriorated to the point at which, in 2012, he went on a hunger strike and began starving himself . . . He lost 40 pounds, drinking only bottled water in the summer heat. A woman who worked in a law office across the street told me she looked over one day and saw him motionless on the sidewalk. “I was going to shake him,” she told me at the time. “I thought he was dead.” [Man] wasn’t, but at the rate he was going, he likely would have been soon. Finally, police and health department officials loaded him into an ambulance and took him to a local hospital. Why didn’t they intervene before then? The answer is simple: Legally, they couldn’t until [he] proved himself a threat to his own safety, the public’s or was gravely disabled. (Jardine 2017)

After his hospitalization he left the streets for a group home. Four years later, he “died . . . his

life no doubt shortened by his mental condition and decade of homelessness.”

The contrast with the “Dangerous Brain Disease” framing is stark. Stories mentioning dangerousness or homicide declined in favor of an emphasis on self-destruction through drugs or victimization at the hands of others (Figure 2). This set a different agenda for reform. From the 1980s to 2000s, advocates wanted to loosen the definition of “danger to self” and “danger to others.” Now, though, reformers focused on altering a third criterion for hospitalization: “grave disability,” or the inability to meet one’s needs for food, clothing, or shelter. One proposal, endorsed by the Board of Supervisors in LA, would declare people “who are unable to seek medical care because of their mental illness” as also “gravely disabled,” under the logic that a “significant number” of deaths on the street are “caused by preventable medical conditions” (Etehad 2018). As interviewees consulted in this research project pointed out, the barriers to life-saving medical care for this group included a lack of health insurance and the unwillingness of some medical hospitals to treat people for physical conditions when they also have psychiatric illnesses. Nonetheless, an editorial in *The Sacramento Bee* promised that “a simple change in one 1967 law” would “avert needless deaths” (Editorial Board 2018).

A second striking transformation in the “Dying on the Streets” frame was how it shifted the agenda from facilitating medication compliance to enabling extended hospitalization. Los Angeles Councilperson Joe Busciano was quoted at a hearing, “We need to find a longer-care solution to those who are mentally ill and homeless on our streets,” namely, by “bring[ing] back institutionalization” (Reyes and Curwen 2018). Depictions of how people with mental illness were failing to meet their most basic needs justified nostalgia for an institution that did. One letter writer recalled wistfully, “before the [LPS] Act . . . the homeless mentally-ill . . . were housed in the state-run mental hospitals” where they “had food, medical care, [and] shelter” (Farrington 2016:10). One commentator insisted in multiple Op-Eds that “closing state mental hospitals was a disaster” (Spotswood 2018). The problem stemmed not just from Reagan’s cost cutting but also from Democrats who had “see[n] the film ‘One Flew Over the Cuckoo’s Nest’ one time too many” (the film was released in 1975, eight years after LPS was enacted) and who were in

thrall to “utopians believing no one should be involuntarily hospitalized.” The author suggested “promptly abolishing [LPS] and properly funding 21st-century residential state hospitals” to provide “lifetime mandatory psychiatric care.”

In 2017, Senator Scott Wiener, a Democrat from San Francisco, proposed a bill that would ease the process of putting homeless people with both mental illness and substance use into “conservatorships,” a legal tool under LPS to force someone into a locked facility for an extended period. Attention to conservatorship rose alongside discussions of more beds in debates about reform (Figure 4). Wiener’s advocacy mixed humanitarianism and paternalism: in the *San Francisco Chronicle*, he answered his critics by stating, “Allowing someone to deteriorate and die on our streets, allowing someone to sleep in their feces, that’s not progressive, it’s not compassionate, it’s frankly the opposite . . . We need to help these people” (Knight 2019:C1). Confronted with the idea that this threatened civil liberties, Wiener replied, “We do [already] have a very large conservatorship program in California—it’s called jail” (Wiener 2018). Rhetorically, the “Dying in the Streets” frame suggested the debate about “de-institutionalization” was over. The public and policymakers just needed to decide whether they preferred institutionalization in jails, homeless shelters, or hospitals.

CONCLUSION: REWRITING THE MAGNA CARTA

Fifty years after its passage, even the positive framings of LPS have been turned on their head. In 2012, a major report on reforming LPS declared that the law was a “Magna Carta of civil rights” but only “for those individuals who are well enough to respond to treatment in a voluntary mental health treatment system” (LPS Reform Task Force II 2012:4). The law’s intentions were at best misguided: one op-ed declared that “LPS—revolutionary and respected fifty years ago, [is] now the Model T Ford of state commitment laws” (Bernard 2020). Coverage has not, however, followed a straight line from celebration to derision or from concern about civil liberties to fears of violence. Instead, it veered through five relatively discrete frames. Each linked together different sets of problematic conditions tied to mental illness, interpretations of how they

originated in specific aspects of the bill, and an agenda for reform.

This article presents newspaper discourses as a classic case of how “social problems” emerge from a “process of collective definition” rather than “existing independently as a set of objective social arrangements” (Blumer 1971:298). There is no evidence that people with severe mental illness actually started committing more homicides around 2000 or only began dying for lack of life-saving medical care in the last few years. Rather, media framings of LPS reveal where the social fabric is already fraying. In the 1970s, critiques of LPS betrayed growing disillusionment with the utopian instincts of the 1960s; in the 1980s, they fit into broader concern about the collapsing social welfare system under Reagan. Today, they reflect doubts about the ability of progressive urban regimes to handle disorder and drug use on the streets.

A first core finding in this article is that all five frames suggested LPS was responsible for outcomes—like rising homelessness—which actually had much broader causes in shifts in government policy and social structure. Goffman (1986:22) argues that frames “provide background understanding for events that incorporate the will, aim, and controlling effort of an intelligence [or] a live agency.” By implying that social problems were a direct if unintended consequence of the “will” of the legislators that wrote LPS, coverage held up the false promise that these problems could be reversed simply by changing the law and limiting people with mental illnesses’ civil rights.

In addition to identifying *what* problems the media placed on the public agenda, a second finding of this article concerns *whose* voices dominated. Through the 1970s, the heads of mental health departments and clinicians were trusted expert sources. Starting at the 1980s, however, family members were the most frequently quoted constituency, which continued until 2010, when government officials gained primacy. People identified as current, former, or potential patients were included in a little less than 10 percent of feature-length articles over the total sample, less than half as frequently as family members. The well-documented rise of the mental health “consumer” or “survivor” movement (McLean 1995) was only partly matched by greater attention to its positions and perspectives.

The period from the 1990s to 2010s, where advocacy groups and family members dominated

discussion, was also the epoch where public opinion surveys observed a puzzling combination of increasing endorsement of genetic origins of illness, support for biomedical treatment, and fear of people with mental illness (Pescosolido et al. 2010; Phelan et al. 2000). Scholars have speculated that this may be a side effect of the way that biomedical narratives “enhance notions of ‘otherness,’ reduce treatment optimism and aggravate anticipations of unexpected and dangerous behaviour [*sic*]” (Schomerus et al. 2012:449). This article suggests, however, that this linkage could have been formed directly by how advocates explicitly argued that people with brain diseases could recover if medicated—and would be dangerous if not. Although today we associate these narratives with opportunistic politicians, the advocacy community might need to interrogate its own role in creating this linkage.

A third core contribution of this article is to identify a new framing, “Dying on the Streets,” which has received less attention in recent work focused on the nexus of mental illness and violence (Frankham 2020; McGinty et al. 2014). The frame accentuates concerns about homeless people articulated in the “Excessive De-institutionalization” frame and partly displaces the safety concerns about “Dangerous Brain Diseases.” As in discussions of the opioid epidemic, this frame “medicalizes” rather than “criminalizes” drug use and disruptive behavior (Netherland and Hansen 2017; Shachar et al. 2020). But its emphasis on long-term hospitalization as an act of urgent compassion is an example of how coercive medicalized approaches can be. These stories very rarely mentioned hopeful tales of “recovery,” and instead focus on the need to ensure bare survival and less-disorderly public spaces. Future studies of stigma should consider whether these themes are also present in public opinion.


In 1961, Erving Goffman (1961:384) speculated that “if all the mental hospitals . . . were emptied and closed down today, tomorrow relatives, police, and judges would raise a clamor for new ones.” Goffman undersold the impact of his and others’ critiques of institutional psychiatry and the bad taste (both fiscal and ethical) that state hospitals left in the public’s mouth. For decades, advocates pushed for better-funded community services, looser criteria for short-term hospitalizations, and court-mandated outpatient medication as alternatives to assuage its own fears about the

mad living outside asylums. This article suggests waning patience for these attempts to patch up the problems attributed to de-institutionalization. If “media narratives matter because they shape and are bellwethers of solutions to public policy problems” (Shachar et al. 2020:234), it remains to be seen whether the clamor to which these representations are contributing will succeed in rewriting the “Magna Carta” of 1967.

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NOTES

1. The choice of terminology is complex. Some “consumers” or “survivors” of mental health treatment have attempted to reclaim the term “madness” while rejecting the medical qualification of “illness” (McLean 1995). Other advocates have tried to valorize conditions like schizophrenia as “real” illnesses by referring to them as “neurobiological” or “brain” disorders. Many of the articles talk about “the mentally ill.” I adopt “mental illness” as the most neutral designation but use variants of “person-first” language when practical, that is, “people living with mental illness.”
2. Because the coding grid involved a large number of variables, many of which were not present in most articles, a more conservative test of reliability was performed by removing all cells where both coders indicated that a given topic was not present. Comparing only items where at least one researcher coded a topic as present yielded a kappa of .80, which is at the cusp between “substantial” and “almost perfect” reliability (Landis and Koch 1977).
3. California Welfare and Institutions Code [5001]. Retrieved December 8, 2020 (<https://leginfo.ca.gov/>).
4. These extensively reported concerns about excessively rights-conscious judges and lawyers were not born out by sociological research at the time. Studies instead found that many jurists did not aggressively use the avenues created by laws like LPS to advocate for patients to be released (Hiday 1981; Holstein 1993; Warren 1982). Instead, rapid discharges from

hospitals were driven by limitations insurance companies placed on payments for inpatient psychiatric care.

5. People identifying as mentally ill did not speak with one voice. Multiple letter writers told stories like that of someone who knew that “had I not received care for my schizo-affective disorder, I would be dead . . . [and] perhaps have harmed someone else as well . . . I have had multiple hospitalizations, been restrained in four-point restraints, and given medicine against my will. It is with hindsight that I am grateful to those who treated me” (Anonymous 2001:A24).
6. There was an alternative discourse that evinced disgust and frustration, not humanitarian concern. A retired district attorney wrote the *Orange County Register* to say that “Having been accosted in Santa Ana many times by obviously ill or intoxicated homeless people demanding money, I share the public’s dislike of the homeless. The homeless are there because of the [LPS] Act, which closed state hospitals and just dumped people” (Estes 2014).

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