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Mental Illness Diagnosis and the Construction of Stigma

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by

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Abstract

This dissertation explores how mental health legislation and related policy documents contribute to identification, diagnosis, and stigmatization. Using a mixed methods approach including content and stylometric text analysis with R as a heuristic for close and critical reading, I demonstrate how these documents normalize mental health concerns as a public threat. To do this work, I analyze how the Florida Mental Health Act (Chapter 394) and the Florida Marjory Stoneman Douglas High School Public Safety Act (SB 7026) circulate and sustain dominant narratives about mental illness. I trace where these narratives are distributed into Florida school districts' mandatory mental health plans. These mental health plans govern the identification, surveillance, and threat assessment of K-12 students based on their perceived mental status. Students identified as potential threats are referred to and tracked by school district personnel and local law enforcement. Policies like Chapter 394 and SB 7026 identify students as threats reinforce stigma for those experiencing mental health concerns. Richly describing the connection between stigmatization, policy, and privilege helps the field better understand the biopolitics of diagnosis and treatment.

Chapter 1: Introduction

On February 14th, 2018, a student with a history of behavioral and disciplinary concerns shot and killed seventeen people, and injured seventeen more, at Marjory Stoneman Douglas High School (MSDHS) in Parkland, Florida. In the wake of this tragedy, the state of Florida launched an investigation into the causes of the shooting. The investigation revealed that the shooter had maintained previous contact with the state's Mental Health (MH) system until aging out of MH care at age eighteen. In response to the shooting, investigation, and calls for gun control reform, Florida's legislature proposed sweeping changes in MH legislation, codified in the 2018 Marjory Stoneman Douglas High School Public Safety Act (MSDHSPSA), or SB 7026. As SB 7026 is named for MSDHS, the legislature has drawn a link between the school's tragedy and the policy enacted in response to that tragedy. The purpose of SB 7026 (2018) is to "comprehensively address the crisis of gun violence...on school campuses" (line 305). The processes mandated by SB 7026 include the requirement that school districts identify students with MH concerns and then assess the threat posed by these students. 85 percent of Florida school districts use retention data to inform their threat assessment protocols. Retention data includes factors like absenteeism, failing grades, and low performance on standardized test scores (Brundage, 2014; "Florida Problem Solving/Response to Intervention Project Early Warning Systems Support," n.d.). As this dissertation confirms, retention data are not likely to be correlated with either MH concerns or a student's potential for violence, but these data are likely to be correlated with students who lack racial, socioeconomic, and other forms of privilege. Once identified under school districts' MH protocols, students must be threat assessed by both school district personnel and local law

enforcement. Student data is required to be entered into a state-level data repository that has no expiration or deletion guidelines, so the state may possess even inaccurate information about a student's MH condition or potential for violence in perpetuity (Schaffhauser, 2019). By linking academic achievement to MH to gun violence so explicitly, the MH legislation studied in this dissertation risks labeling already marginalized students as mentally ill and potentially violent. These labels are assigned to students for the remainder of their time in Florida schools, reinforcing students' marginalized status via the stigma associated with having a MH condition and increased contact with law enforcement. When an individual is identified as a person with MH concerns, the individual is determined to need correction or cure. If the individual's MH concerns are not mitigated to the extent required by MH legislation, then MH legislation may mark individual's behavior as a potential threat. In some cases, MH legislation may require that individuals with MH concerns be involuntarily committed for MH evaluation or treatment. For students, involuntary commitment and the protocols that follow their return from involuntary commitment confirm the misconception that many people with MH concerns are potential threats to public safety, resulting in further MH stigma against them.

In this dissertation, I study how MH legislation, including state level regulations and school districts' policies and protocols, constructs individuals with MH concerns as potential threats to public health and safety. This MH legislation studied reinforces misconceptions about mental illness and increases stigma toward individuals who may need MH care. It also enacts biopolitical control over individuals by labeling them as individuals with MH concerns and then requiring mandatory MH treatment so that so that these individuals can recover or "return to normalcy," as multiple school districts state. I engage with several linked concerns in this dissertation: 1) the mis/connection between MH and gun violence that produces policies

regulating individuals with MH concerns' supposed propensity for violent behavior; 2) the ways that legislation normalizes MH concerns as a disability that must be cured through MH education and treatment; 3) the dispersal of dominant narratives about MH into local policies and protocols that further stigmatize vulnerable students; and 4) the need to create better practices for MH assessment in our research, teaching, and administrative work.

Research Problems

Legislatures often promote MH legislation as an intervention to reduce incidents of gun violence in U.S. schools. While many gun safety advocates point to stricter firearms regulations as a way of ensuring school safety, such regulations often face opposition from the firearms lobby (Zurcher, 2019). Instead, regulations to support school safety focus on MH, an initiative that commonly leads "red flag" bills to receive bi-partisan support (Daly, 2019; Peters, 2013). Red flag laws purport to address public safety by identifying people who may require MH treatment. The connection between the two suggests that legislatures and the public they are supposed to represent view people with MH concerns as threats to public safety. As Paul Applebaum, an expert on psychiatry and ethics, comments about red flag laws and school safety, "The general concern that I have is that in the wake of horrific events like Virginia Tech and Newtown…there's been a concerted effort by the NRA to distract attention from questions of the availability of guns and particularly those with high capacity, and instead to point the finger at the mentally ill because it's always easier to do that" (qtd. in Ollove, 2013). A 2017 Pew Research poll supported the apparent mis/connection between gun violence and mental illness: 89 percent of those surveyed were in favor of gun restrictions for those with mental illnesses (Parker et al., 2017). Laws that link mental illness with the potential for violence risk labeling every person with a mental illness as potentially violent. As the National Alliance for Mental

Illness notes, most people with mental illnesses are not violent ("Extreme Risk Protection Orders," 2020). Medical experts agree that most people with MH concerns are not violent. Applebaum & Swanson, 2010, and McGinty, Webster, & Barry, 2014 are echoed by credentialed experts writing through non-peer-reviewed mediums (Swanson, 2011; Hall & Friedman, 2013; Rosenberg et al., 2015) and by journalists (Friedman, 2012; Nuwer, 2018). Yet these bills continue to be passed despite their tendency to conflate MH concerns and violence and a lack of evidence for their efficacy (RAND Corporation, 2018; 2019). While some evidence suggests that young, white men (Leveille & Mizner, 2017) are responsible for many violent acts of this nature in the United States, non-discrimination laws prohibit discrimination based on classifications like race and gender. Identifying people with potential MH concerns, however, is permissible under these statutes. While these acts may aspire to remove threats to public safety and satisfy the desire to respond resolutely to tragedy, they may not identify the individuals who are statistically most likely to be threats to public safety. As such, laws that label people with mental illnesses as potential threats to public safety risk normalizing the misconnection between MH and gun violence.

This dissertation's analyses of legislation, stigma, and disability draw on theories from multiple fields, including technical and professional communication (TPC), rhetoric of health and medicine (RHM), and disability studies. This project is informed by TPC's understanding of the material impacts of policy documents and the long-term impacts of policy that constructs individuals as risks. My focus on the material-discursive processes by which people become patients is influenced by work in RHM (Walkup & Cannon, 2018; Cannon & Walkup, 2021). Disability studies scholarship helps me explore how the ideology of cure can influence an individual's designation into binary normal/abnormal categories (Holladay & Price, 2019; Clare,

2017; Puar, 2017). I draw upon this fields to help me understand this dissertation's research problems and will discuss how each undergirds my work below.

Policy Documents Normalize Misconceptions

Policies and protocols connect to and change their surroundings. For TPC, texts mediate knowledge, values, and action (Rude, 2009). Focusing on texts and the contexts they create is "dynamic and generative" (Rude, 2009, p. 175). In my project, texts construct and change mental health (MH) to explain how dominant narratives about MH, academic achievement, and violence interlock, to imply that marginalized students are threats. Dominant narratives, expressed through policies, normalize the construction of individuals with MH concerns as risks. As TPC scholars have found, institutions drive designation of risk and/or threat. Institutions' risk communication can influence public opinion (Nagelhout et al., 2009). Institutions create policies as responses to uncertainty (Walker & Walsh, 2012; Propen, 2015). Walsh and Walker (2016) note that "individual perception of uncertainty is powerfully connected to risk perception" (p. 76). The uncertainty itself becomes the risk. In my project, uncertainty about whether individuals with MH concerns are risks for causing gun violence has been influenced by powerful institutions, including the gun lobby, conservative news media, and political conservatives. For example, until recently, the 1996 Dickey Amendment prevented federal funding of gun violence research (Rostron, 2018; Subaraman, 2019). The lack of research on the causes of gun violence contributed to further uncertainty about its causes, leaving policies to manage perception of risk.

Technical writing is often viewed as "objective, apolitical, [and] acultural," as Jones et al. (2016) note. Policies and protocols seem like objective institutional responses to a crisis, but as Balzhiser et al. (2019) find when analyzing Census forms, seemingly objective technical writing artifacts "institutionalize discourses and influence thinking and behavior when people in

authority endorse that information by using the form and passing it along to respondents" (p. 4). The authors assert that institutional discourses simplify the classification of individuals in discriminatory or dehumanizing ways. These mediating technical documents form the infrastructure of institutions (Read, 2019, p. 255). Institutions, along with their rules and regulations, are pervasive, writes Johnson (2014, p. 386). When rules and regulations become institutionalized, they may not be able to respond with agility to the complex social systems they regulate. In my project, the documents I study are an aspect of infrastructure that points to individuals with MH concerns as a risk to public safety. They normalize management of these individuals (and their MH concerns) as the response to gun violence.

Critical analysis of policy documents in TPC generally examines communication breakdowns and the large-and-small scale problems influenced by documentation. TPC scholars often look to policies and protocols to make sense of tragedy. Marsen (2014), for example, examines sensemaking after the Challenger disaster, while Devasto et al. (2016) explore responsibility and risk communication after the L'Aquila earthquake. Examination of policies and protocols can illuminate the networks of stakeholders that construct the institutions that author them. As Devasto et al. (2016) find, scientific policy's "purification and procedure" is a way of understanding a larger debate about democracy and expertise (p. 136). This debate also coalesces in Weber's (2013) analysis of corporate social media policy. Here the trouble comes from legalities of assumed institutional authority over employee voice, and Weber (2013) closes by questioning the authority of policies to dictate actions. Policies help institutions regulate their stakeholders; policy critiques examine the problems these regulations cause.

MH Mis/diagnosis and Stigma

Stigma, defined generally as a mark of disgrace, crosses discursive and medical boundaries when applied to MH. Stigma is often viewed as the greatest barrier to treatment access (Pellegrini, 2014; Corrigan, 2014). MH stigma is often viewed as a personal problem that individuals with potential MH concerns should overcome in order to access MH treatment, i.e. self-stigma. As Corrigan and Rao (2012) assert, however, "Public stigma…represents the prejudice and discrimination directed at a group by the larger population. Self-stigma occurs when people internalize these public attitudes and suffer numerous negative consequences as a result" (n.p.). Public attitudes toward MH can contribute to self-stigma. As a consequence, the National Alliance for Mental Illness (NAMI) (2020) writes: "Stigma causes people to feel ashamed for something that is out of their control. Worst of all, stigma prevents people from seeking the help they need." As my dissertation shows, stigma results in material consequences, like increased contact with school district personnel. When an individual is perceived to have an MH condition and threat assessed accordingly, MH stigma may prevent the individual from seeking additional care. A person with a potential MH condition must then navigate resources for treatment while convincing both MH and public safety professionals that they are not a threat. These MH contortions are difficult and may prevent individuals from accessing the MH treatment appropriate for their needs.

Consequences of MH mis/diagnosis continue to impact both MH treatment and MH stigma. Florida's best practices for school safety specifically address the school-to-prison pipeline; Cowan et al. (2013) write that "using security personnel or SROs primarily as a substitute for effective discipline policies does not contribute to school safety and can perpetuate the school-to-prison pipeline" Furthermore, SB 7026 comments on the need to seek non-

suspension disciplinary measures. These actions show that some awareness of the conflation of MH and the threat of violence exists. Yet references to disciplinary measures continue, and so too do problematic assumptions about people with MH concerns. Without reminders of the consequences of identification, MH legislation is vulnerable to perpetuating these consequences through its enactment of mental illness.

Mental illness is enacted differently depending on person, place, provider, and diagnosis, among other factors. Different enactments lead to multiple ontologies of illness, which can impact how a person identifies or is identified as a patient (Teston, 2017; Mol, 2003). Scholarship on MH often examines the discursive practices that construct diagnosis and the ways that (mis)diagnosis can contribute to MH stigma (Hanganu-Bresch & Berkenkotter, 2019; Yergeau, 2018; Price, 2011). Pointing to institutions as drivers of MH stigma can counter the misconception that the self-stigma is the primary barrier to MH treatment. Gaudet (2019) illustrates the harm that comes from this concept of stigma in an analysis of mental illness awareness campaigns. As Gaudet (2019) notes, the problem with self-stigma is that "a stigmatized person is always dependent on the existence of a normative social body, while the normalcy of such a social body is reaffirmed through the categorization and othering of those who deviate from these rules" (p. 159). The institutional labeling of individuals with MH concerns as deviant causes stigma, and with stigma comes rhetorical disability (Miller, 2019; Price, 2011; Johnson, 2010). Remediating the social construction of stigma in this way is a means of enacting recuperative ethos (Molloy, 2015) and resisting dominant narratives about MH.

Medical knowledge depends on its texts and contexts; RHM scholarship examines how medicine is mediated through discourse. As Angeli and Johnson (2018) suggest, rhetorical

mediation changes health communication, patient education, and evidence-based medicine. Mediation occurs within a complex network of patients, healthcare providers, technologies, and other actors that form and inform an individual's MH. This networked approach helps me question MH legislation's insistence on identification of individuals with MH concerns. Identification, based on markers like academic achievement, serves as a form of diagnosis. In a study of disability treatment paradigms, Stuckey (n.d.) determines that the act of diagnosis creates separate categories between patients who meet certain qualifications and those who do not. These taxonomies, Stuckey notes, can be epideictic. Also writing about category error in health records, Popham and Graham (2008) find that electronic MH records rely on categories of diagnosis that may limit communication between care providers and patients. Kelly's (2020) analysis of the Diagnostic and Statistical Manual of Mental Disorders (DSM) finds that diagnosis "[presents] mental disorders as discrete, stable entities located in the body and visible to observers" (p. 235). Similarly, in MH legislation, identification and diagnosis are presented as solutions to the uncertainty of individuals with MH concerns.

MH legislation's focus on identification also perpetuates inaccurate ideas about the progress of mental illnesses. SB 7026 emphasizes identification and treatment access; Chapter 394 manages treatment logistics. These objectives aren't necessarily negative. As Adams (2010) notes, earlier access to treatment improves health outcomes. Yet when diagnosis uses factors like students' academic performance, MH legislation may imbricate students into unneeded or unwanted medical treatment. Using a rhetorical perspective, Reynolds (2018) finds that mental illnesses are discussed as fixed conditions that can be overcome, which influences the ways that mental illnesses can become real. Identification brings an MH concern into being, while medical treatment overcomes the MH concern. This narrative of medical progress can result in

constructing medical conditions as narratives of diagnosis, treatment, and recovery, as Pienaar and Dilkes-Frayne (2018) find. However, these medical narratives are often inaccurate. For example, students may be identified with a potential MH concern for reporting being bullied (Schaffhouser, 2019). Misdiagnosis might impact the perceived efficacy of MH care. Even for individuals who are correctly identified with MH concerns, medical narratives about mental illnesses suggest that MH treatment will alleviate the symptoms that caused the diagnosis which is not necessarily the case; many individuals experience recurrent mental illness and make regular attempts to access treatment (Kartalova-O'Doherty & Doherty, 2010). Treating mental illness as something that can be permanently cured disadvantages those whose symptoms are not alleviated through medical treatment.

Problems with the Ideology of Cure

MH legislation that focuses on an individual's early identification and treatment has the potential to disadvantage many groups of stakeholders, including 1) those who are denied identification and access to wanted MH treatment, 2) those whose MH concerns do not conform to the narrative of medical progress, and 3) those misidentified individuals, who are exposed to medical treatment they may not want or need. These stakeholder groups are impacted by the medicalization of mental illness, often addressed by disability studies. In disability studies, many scholars view the discourse of recovery as part of the ideology of cure. Under this ideology, individuals with disabilities are othered and deemed in need of intervention to "return" to an idealized original nondisabled state (Clare, 2017). Proposed MH treatments or interventions often use this language of cure, positioning individuals within recovery narratives and incidentally reinforcing MH concerns about individuals with perceived disabled status. In Florida MH legislation, the state legislature perpetuates this ideology, stating that MH treatment for

substance abuse or mental illness ceases when an individual is able to “return to the community” and “live successfully,” (394.453). Presenting MH treatment as a temporary stop on the road to recovery is a perspective that allows for the “economical use” of resources (394.75). For many, presenting MH treatment as a discrete response to a problem does not reflect their lived experience.

Identifying students as individuals with potential MH concerns reinforces binary categories of ability and disability. These binaries are spurious, argues Puar (2017), showing how disability is abstracted from the sociotechnical forces that have contributed to that disability. To avoid replicating the ideology of cure, Garland-Thomson (2011) writes, feminist disability studies scholars should differentiate between prevention and elimination. Preventing further suffering should be the goal, rather than participating in the “eugenic undertaking” of eliminating disability (p. 28). In the same collection, Donaldson (2011) envisions a feminist disability studies theory of mental illness that encompasses embodiment. Theorizing embodiment envisions constraints of mental illness upon the body of a person who has (or is perceived to have) one. Thinking through Donaldson's advice to understand mental illness as “real,” individuals with MH concerns are subject to very real consequences: among them contact with law enforcement and the risk of institutionalization.

Designations about mental illness, including whether individuals have one and to what extent, have long been based on exclusionary practices inherent in medical discourse. Holladay and Price (2020) take exclusion into account, affirming that medical treatment descriptions have often struggled with discrimination based on ability, race, class, and gender. Medical discourses have the potential to harm individuals regulated by them; institutional designations of illness and wellness fold patients into biomedical assemblages that impact being and agency. For example,

Derkatch (2018) finds that illness is presented counter to the language of wellness in biomedical discourse, reinforcing the idea of illness as a risk. Biomedical discourses can normalize misconceptions about mental illness and its impacts on an individual's perceived agency or selfhood. As Takayoshi (2020) points out in a study of historical asylum narratives, individuals present their experiences in contrast to the disabling language of the institution. Holladay and Price (2019) detail how brain scans are often used as proof of a mental illness's existence, but overreliance on the technologies that produce them often counters patient experience, contributing to the idea the MH concerns can be measured. Yergeau (2018) makes a similar argument, noting that "autism is perceived incrementally" and so "no autistic person can ever be autistic enough" (n.p.). Self-diagnosis, though, is fraught with moral and ethical concerns, Yergeau (2018) writes. These and other critiques of health and medical discourse suggest that dominant discourses of MH treatment and disability can co-opt the experiences of individuals with MH concerns.

This project extends from these theories about policy documents, stigma, and disability to examine the discursive construction of MH and redress the harms caused by institutional policies and protocols. This agenda takes into account the development of this construction over time through various mis/connections: the misconnection between academic achievement and MH, the misconnection between MH and gun violence, and the misconnection between MH treatment and alleviation of MH symptoms.

Contributions

This dissertation*, Mental illness diagnosis and the construction of stigma*, is the first examination of Florida MH legislation and rhetoric. My dissertation examines prominent Florida MH policies and protocols to make three distinct contributions.

This project:

- *Investigates the ways MH is constructed in the legislation and the policies and practices it demands.* My focus on the material-discursive processes by which students are transformed into patients augments medical rhetoric's work on mental health that has addressed how historical discourse marks individuals as other (Hanganu-Bresch and Berkenkotter, 2019; Kearney, 2020). My project responds to those rhetorical scholars who have challenged us to investigate the technologies used to diagnose patients with MH conditions (Yergeau, 2018). It also benefits from welcome criticism of concepts like MH literacy, which when withheld from patients has the power to enact further stigma (Holladay and Price, 2020). To do this work, I particularly connect my project to TPC's understanding of the situated nature of medical truth as constructed by language acts and the long-term impacts of policies based on contingent knowledge. These language acts, discursively distributed through "literally life and death rhetorical situations" (Heifferon and Brown, 2000, p. 245) correspond to the rhetorical events I research in this study. This project is guided as well by theories that suggest that medical research that focuses on finding a "cure" for patients with an MH condition can lead to further MH stigma (Clare, 2017). These theories to shape the language I use to discuss MH and the interventions I eventually propose.
- *Extends TPC's understanding of how policy documents construct risk and reify stigma.* My project explores the intersection of policy documents and risk communication. Work in TPC that operates at this intersection has often prioritized environmental policy (Frost, 2013; Williams & James, 2009) and regulatory controversies (Kessler & Graham, 2018). My dissertation expands our focus to address the consequences of state-level MH policy.

Specifically, I seek to understand how these policy documents construct and reify stigma. TPC scholarship's focus on social justice has highlighted the ways that dominant narratives operate within the field to exclude work that is not considered objective, apolitical, or acultural (Jones et al., 2016). Policy documents and the processes they construct are a concern for TPC scholars because these materials are presented as objective, apolitical, and acultural. For MH policies, the consequences of these dominant narratives include increased stigma. Far from being apolitical and acultural, MH policies and processes engage with current concerns about people with MH conditions and their capacity for violence. By perpetuating the narrative that people with MH conditions should be identified and threat assessed, I argue that MH policies and processes not only construct but reinforce stigma for those they act upon.

- *Argues that policies and legislative practices can make stigma endemic within already-vulnerable communities, combining with structural factors to further marginalize some groups*. Scholarship in TPC has explored the production of raced, gendered, classed, and abled dominant narratives that result in the exclusion and subjugation of minority groups. In particular, these dominant narratives legitimize some bodies while marking others as deviant (Pickens, 2019; Browne, 2015). These narratives also separate bodies from culture and present them as ahistorical, pre-social, and purely natural (Mintz, 2007). Training TPC's attention on dominant narratives of MH and mental ability helps us understand how people with MH concerns have been marked for debility by the state. Using a biopolitical lens, I argue that the population marked for debility is distanced from MH treatment; debility becomes a condition of being within the community (Puar, 2017; Mitchell & Snyder, 2015; Berlant, 2007).

Research Questions

This dissertation focuses on four interconnected research questions:

1. How has MH legislation in Florida addressed the risk of dangerous behavior from individuals with MH concerns? How has the perception of "dangerous" behavior resulted in increased institutionalization of individuals with MH concerns?
2. How does MH legislation in Florida include dominant narratives about people with MH concerns?
3. To what extent are dominant narratives about MH present in school districts' MH plans? How do dominant narratives influence the creation of comparative analytics that label students with MH concerns as potential threats?
4. How can school districts' MH plans avoid the implication that students with MH concerns are potential threats? How can school districts' MH plans break the misconnection between academic achievement, MH, and the potential for violence?

These research questions are answered through multiple research methods: a content analysis of deinstitutionalization and Florida MH law in Chapter 2, a close reading of current Florida MH laws Chapter 394 and SB 7026 in Chapter 3, and computational text analysis of school districts' MH plans produced under SB 7026 in Chapter 4. In Chapter 5, I conclude this dissertation by explaining how school districts can apply these findings within their MH plans, avoiding the assumption between MH and the potential for violence. I also establish a research agenda that enacts the project's findings about MH literacy, education, and assessment.

Methodology

This dissertation uses multiple methods to answer the first three research questions. Each chapter contains further discussion of the method used: content analysis in Chapter 1, close reading in

Chapter 2, and stylometric text analysis in Chapter 3. In this section, I present the artifacts for analysis.

Artifacts for Analysis

I answer my research questions through analysis of MH legislation and related documents[1]. The first text I explore is purportedly the first-recorded MH legislation in Florida, established in 1874. This initial legislation set forth regulations for institutionalization of individuals with MH concerns and, according to the Florida Department of Children and Families, remained relatively unchanged until the creation of the Florida Mental Health Act, or Chapter 394, nearly one hundred years later. Chapter 394 was itself influenced by national MH policy, particularly the deinstitutionalization movement, codified in 1946 with the creation of the National Mental Health Act. Deinstitutionalization, or the reduction of extended-stay psychiatric hospitals or asylums, was a national-level shift in MH treatment. As psychiatric hospitals and asylums were closed, states created new legislation to detail evaluation and treatment practices for individuals with MH concerns. The Florida Mental Health Institute (FMHI) was created in 1967 to "serve as a bridge between university-based research and communities facing a variety of problems related to mental illness" ("History of the Institute," 2020). Charged with numerous goals for state MH reform, the FMHI's mission was to develop MH assessment practices, improve treatment access, integrate care practices, reduce stigma, and track outcomes. I use these historical pieces of legislation to trace the development of the state's influence over individuals with MH concerns and their access to MH treatment.

[1] While this dissertation conducts text analyses of public documents, a study protocol (STUDY 001556) was submitted to the USF IRB as a precaution; the USF IRB confirmed that this project was not human subjects research.

MH legislation also presents an opportunity to determine dominant narratives as they are enacted in texts. These texts can include dominant narratives about individuals with MH concerns. To determine these dominant narratives, I examine SB 7026, the first bill of the Marjory Stoneman Douglas High School Public Safety Act (MSDHSPSA), which mandates changes on school campuses to protect school safety. Under SB 7026, MH mandates include changes to the Federal Firearms Prohibition, a federal law that restricts firearms access to any person under a risk protection order, addressing student MH in school districts, funding for MH in schools, the creation of a MH plan per school district, and mandatory MH education for school district personnel and students (The Florida Senate, 2018). I also examine Chapter 394, commonly known as the Baker Act[2]. Chapter 394's most well-known aspect is that it allows for the involuntary institutionalization and examination of individuals experiencing mental health concerns. These pieces of legislation intersect with a second school safety bill, SB 7030, and a failed third piece of legislation, HB 7065. As evidenced by SB 7030 and HB 7065, the impacts of SB 7026 are still being determined, making this study of dominant narratives in MH legislation particularly useful as additional MH protocols continue to be enacted.

SB 7026 created the Florida Department of Education's Office of Safe Schools, and it is this entity which has generated many of the documents associated with SB 7026, school district MH guidelines, school district MH plans, and other best practices in implementing SB 7026's mandates within Florida schools. The Office of Safe Schools website is also where School Environmental Safety Incident Reporting (SESIR) is recorded, allowing visitors to view alleged safety incidents at school districts[3]. The Florida DOE's Office of Safe Schools website is open to

[2] After representative Maxine Baker (D), of Miami-Dade county.
[3] School districts have been accused of misrepresenting SESIR data by changing the conditions required for reporting (*Florida Supreme Court*, 2019).

the public and many materials from this project were accessed there. These materials include the MH legislation itself, information on the Guardian program that allows certain school personnel to carry firearms on campuses, school districts' MH plans, best practices for enacting MH legislation, required information for school districts' MH plans to provide to receive state funding, as well as mandatory discipline (SESIR) data that schools are required to report.

In all, there are approximately 330 documents available on the DOE's Office of Safe Schools website, with additional documents added each year as the project continues. I examine many of these documents throughout the dissertation. For example, in Chapter 3, I examine SB 7026 and related MH legislation contained on the website, while in Chapter 4, I examine MH plans, best practices, and SESIR data. After SB 7026, other important documents on the Office of Safe Schools site include the 71 Florida school districts' MH plans I study in Chapter 4 and the 69 Florida school districts' MH plans submitted for the academic year 2019-2020. MH plans are due each year in August. These MH plans carry out the mandates of SB 7026 and control the actions of Florida's roughly 2,756,944 public school students (Lieberman, 2020). While SB 7026 does not mandate school districts' MH plans, it does require particular components. School districts' MH plans are then determined through a process of state-level best practices and local-level decisions by the school districts' threat assessment team, made of school district personnel and local law enforcement. The Office of Safe Schools provides multiple documents to school districts to assist them in understanding the required components of MH plans, without which school districts may lose millions of dollars in funding. The Office of Safe Schools provides a focus point for this study, as it contains most of the documents needed for textual analysis: SB 7026, best practices and implementation guidelines, and school district MH plans.

The confluence of policies and protocols associated with SB 7026 are particularly of interest because SB 7026 has been associated with multiple controversies in Florida. First, SB 7026 authorizes the Guardian program to increase the number of armed personnel in school districts; every school district in the state is now required to have a school resource office (SRO) on campus. Additionally, SB 7030, builds on the Guardian program to allow teachers to carry firearms in classrooms. SB 7026's proposed student data repository has also been criticized by numerous stakeholders, including 33 advocacy organizations in an open letter to the state's governor. In the letter, the advocacy organizations, including the Florida ACLU, Florida League of Women Voters, Southern Poverty Law Center, and the Electronic Frontier Forum, write "without safeguards and protections, the state risks building a structure to systematically discriminate against students based on protected statuses" ("Highlighting risks arising from Florida's proposed school safety data base," 2019). Moreover, March for Our Lives Florida, an organization founded in response to the tragedy at Marjory Stoneman Douglas High School, with leadership including some MSDHS students, is named as a plaintiff in a lawsuit against the MSD Commission, the group responsible for the recommendations enacted in SB 7026. As the lawsuit alleges, the MSD Commission silenced "a voice the Commission has ignored—that of the very students it was created to protect" (Filing # 101707070, 2020). These multiple points of controversy suggest that SB 7026 contains numerous inflection points where public officials, advocates, and students disagree. Given these numerous inflection points, SB 7026 presents an opportunity to study the intersections of MH, stigma, gun violence, and social justice in technical communication.

Overview of Chapters

This dissertation examines MH stigma as the material labeling of students as dangerous or deviant based on their perceived MH status. While this labeling is material, in that student names are being collected in a state database, being shared with school personnel and law enforcement, and student answers to threat assessment interviews can result in involuntary examination, I also examine the dominant narratives underpinning its existence. Each dissertation chapter pursues my goal of exploring how technical communicators can intervene when policy documents threaten to harm vulnerable populations. I begin the study by examining the origins of MH policy in Florida; the Florida MH Act, also called the Baker Act. In Chapter 2 I analyze two points of contention in the Florida MH act: the determination of "dangerousness" as a criterion for involuntary examination and the use of law enforcement officers to carry out a majority of transfers to involuntary examination. In Chapter 3 I build on these contentions by finding dominant narratives within the Florida MH Act and SB 7026. I show how state MH laws normalize surveillance and control over individuals with MH concerns for the purpose of protecting public safety. Chapter 4 carries forward the theory of dominant narratives about MH , as I study Florida school districts' MH plans through stylometric text analysis with R. In Chapter 5 I demonstrate how MH stigma is constructed via MH policy. Chapter 5 also puts forth a research agenda to apply the theories about MH in this project and intervene within policy debates to compose better policies for school safety. I describe these chapters in more detail below.

In this dissertation, I examine MH stigma as the material labeling of students as dangerous or deviant based on their perceived MH status. While this labeling is material, in that student names are being collected in a state database, being shared with school personnel and law

enforcement, and student answers to threat assessment interviews can result in involuntary examination, I also examine the dominant narratives underpinning its existence. Each dissertation chapter addresses another part of this argument, pursuing my goal of exploring how technical communicators can intervene when policy documents threaten to harm vulnerable populations. I begin the study by examining the origins of MH policy in Florida; the Florida MH Act, also called the Baker Act. Chapter 2 analyzes two points of contention in the Florida MH act: the determination of "dangerousness" as a criterion for involuntary examination, and the use of law enforcement officers to carry out a majority of transfers to involuntary examination. Chapter 3 builds on these contentions by finding dominant narratives within the Florida MH Act and SB 7026, contributing to the argument that state MH laws normalize surveillance and control over individuals with MH concerns for the purpose of protecting public safety. Chapter 4 carries forward the theory of dominant narratives about MH into Florida school districts' MH plans through stylometric text analysis with R. Chapter 5 functions as a conclusion to this argument, demonstrating how MH stigma is constructed via a variety of laws, policies, and practices. Chapter 5 also contains a research agenda to apply the theories about MH in this project and intervene within policy debates to compose better policies for school safety. I describe these chapters in more detail below.

In Chapter 2, I construct a content analysis of the communication of individuals with MH concerns as risks to public safety through the potential for their dangerous behavior. I use this content analysis to determine how MH stigma is constructed through the material-discursive marking of individuals with MH concerns as deviant, a process of othering. This rhetorical process has largely succeeded in normalizing dominant narratives about mental health, narratives that present individuals with MH concerns as potential threats to public safety who must undergo

MH evaluation and treatment in order to function successfully in society. This content analysis of MH legislation and media coverage allows me to determine why this process has been successful and presents an intervention point for scholars of risk communication. Because individuals with mental illnesses have been erroneously marked as risks to society, redressing stigma requires eliminating the perceived risk. When the risk is being constructed and maintained by state institutions and documents, eliminating that risk requires changing the misconceptions about mental illness and violence that circulate within these institutions. I ask how campaigns that purport to reduce MH stigma can succeed in the face of MH legislation that continues to mark individuals with MH concerns as deviant others. As long as these campaigns treat stigma as a purely discursive force, individuals with MH concerns will continue to be marked for elimination. As such, this chapter contributes to scholarship about the ethics of risk communication. Based on this analysis, I identify key findings for risk communication scholars seeking to redress MH stigma. The next chapter continues my analysis by identifying dominant narratives about MH within two pieces of MH legislation.

Chapter 3 identifies narratives about mental health (MH) circulating within and beyond two influential pieces of mental health (MH) legislation: the Florida MH Act (Chapter 394) and the Marjory Stoneman Douglas High School Public Safety Act (SB 7026). In this third chapter of my dissertation, I demonstrate how this legislation constructs individuals with MH concerns as potential threats to public safety, normalizing an unproven link between gun violence and mental health. These dominant narratives about MH reinforce binary categories of ability and disability, marking individuals with MH concerns as deviant others who must undergo MH evaluation and treatment to protect public safety. Presenting MH evaluation and treatment as a requirement for individuals with MH concerns evokes the ideology of cure, further designating individuals with

MH concerns as deviant individuals whose MH concerns must be eliminated. Under these dominant narratives, individuals who do not consent to MH evaluation and treatment may be deemed incompetent and may be involuntarily committed. By enacting this legislation, the state takes on the responsibility of identifying, evaluating, surveilling, and assessing individuals with MH concerns. Dominant narratives about MH justify the continued surveillance and monitoring of individuals with MH concerns. The close and critical reading of Chapter 394 and SB 7026 that undergirds my analysis in this chapter provides a methodological counterweight to the stylometric text analysis with R that follows in Chapter 4 as I trace how these narratives have permeated Florida school districts policies and procedures. My mixed methods approach shows how the state has assumed responsibility for the identification, treatment, and monitoring of individuals with mental health concerns, primarily via techniques of surveillance and control that further disadvantage already marginalized students.

In Chapter 4, I conduct stylometric text analysis on MH plans to indicate the presence of dominant narratives. I use the results of this analysis to identify MH plans that contain more language related to dominant narratives and also to support my critique of SB 7026's mandate to develop a data repository on students who have been identified on basis of their MH concerns. To do this analysis, I overview the role of MH plans in carrying out the mandates of SB 7026, emphasizing in particular critiques about the MH plans' potential to label students with MH concerns or as potential threats. Then I perform stylometric text analysis via cosine similarity on 71 MH plans from 2018 to determine the prevalence of dominant narratives within their text. I continue stylometric text analysis via n-gram and bi-gram frequencies on sampled corpora to illustrate the efficacy of the original cosine similarity tests. I draw these two analyses together to illustrate the contingency of comparative analytics in determining results, noting that while

computers can differentiate variability between data points, humans are ultimately responsible for determining what level of variability is acceptable, and thus for perpetuating the dominant narratives of MH. The next chapter concludes my analysis of dominant narratives within mental illness diagnosis and the construction of stigma by identifying new directions for research on MH education and risk communication.

In Chapter 5, the conclusion of this dissertation, I address how technical communicators and medical rhetoricians can work toward intervention in our research, teaching, and administrative practices toward better MH assessment. As the analyses in Chapters 2, 3, and 4 demonstrate, policy documents can normalize the marginalization of vulnerable communities through increased stigma, surveillance, and control. In addition, these analyses illuminate the role that legislation plays in identifying, diagnosing, and stigmatizing individuals with MH concerns. While MH diagnosis is often considered an act of medical decision-making negotiated between a person and their healthcare provider, this dissertation shows how policy documents can also influence that diagnosis, especially because much medical decision-making under many of the MH protocols I study does not include a healthcare provider. The connections that this dissertation makes between stigmatization, policy, and privilege helps technical communication scholars better understand the biopolitics of diagnosis and treatment.

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Chapter Two: Deinstitutionalization, Danger, and *Parens Patriae*

In this chapter, I contribute a content analysis of previous mental health (MH) legislation, alongside news coverage of MH legislation, focusing on how individuals with MH concerns are presented as risks to public safety through the potential for their dangerous behavior. I use this content analysis to determine how MH stigma is constructed through the material-discursive marking of individuals with MH concerns as deviant, a process of othering. This rhetorical process has largely succeeded in normalizing dominant narratives about mental health, narratives that present individuals with MH concerns as potential threats to public safety who must undergo MH evaluation and treatment in order to function successfully in society. This content analysis of MH legislation presents an intervention point for scholars of risk communication. Because individuals with mental illnesses have been erroneously marked as risks to society, redressing stigma requires eliminating the perceived risk. When the risk is being constructed and maintained by state institutions and documents, eliminating that risk requires changing the misconceptions about mental illness and violence that circulate within these institutions. I ask how campaigns that purport to reduce MH stigma can succeed in the face of MH legislation that continues to mark individuals with MH concerns as deviant others. As long as these campaigns treat stigma as a purely discursive force, individuals with MH concerns will continue to be harmed. As such, this chapter contributes to scholarship about the ethics of risk communication. Based on this analysis, I identify key findings for risk communication scholars seeking to redress MH stigma.

Research Questions

This dissertation focuses on three primary research questions:

1. How has MH legislation in Florida addressed the risk of dangerous behavior from individuals with MH concerns? How has the perception of "dangerous" behavior resulted in increased institutionalization of individuals with MH concerns?
2. How does MH legislation in Florida include dominant narratives about people with MH concerns?
3. To what extent are dominant narratives about MH present in school districts' MH plans? How do dominant narratives influence the creation of comparative analytics that label students with MH concerns as potential threats?
4. How can school district's MH plans avoid the implication that students with MH concerns are potential threats? How can school district's MH plans break the misconnection between academic achievement, MH, and the potential for violence?

I begin answering Research Question 1 in this chapter through constructing a content analysis of Florida MH legislation. In Chapter 3, I use this content analysis, combined with scholarship in disability studies and rhetoric of health and medicine, to identify dominant narratives circulating within MH legislation through close reading. In Chapter 4, I couple my close reading with stylometric text analysis in R to locate the prevalence of dominant narratives with school districts' MH plans. These three interlocking methods reinforce my argument that the state is constructing students with MH concerns as potential threats to public safety, leading to their stigmatization.

Spurious Connections between Guns, Violence, and Mental Illness

Legislatively, gun violence and mental illness are linked. For example, the Federal Firearms Prohibition limits a person who has been "adjudicated as a mental defective" or "committed to a mental institution" from "shipping, transporting, receiving, or possessing any firearm or ammunition" (922g4). The 2018 Florida Marjory Stoneman Douglas High School Public Safety Act (SB 7026) requires school districts to, among other actions, create MH plans to reduce gun violence on school campuses. These two pieces of legislation are typical in that they imply that individuals with mental illnesses may be violent. And this implication is not limited to federal and state law. For example, Price (2011) examines the connection between gun violence and mental illness in a media analysis of articles about two school shooters, observing that article headlines imply that school shooters have "secret lives" that explain their violence (p. 144). Mental disability[4] is positioned as the cause of violence, resulting in the "[construction of] prevalent beliefs about mental disability, violent behavior, and academe" (p. 144-145). The connection drawn between mental illness and violence persists despite research showing that most individuals with mental illness are not violent.

As I have explored in the introduction of this dissertation, research suggests that there *should be* no connection between mental illness and violence. However, the connection is perpetuated via laws, media, and public perception, so in this chapter I seek to understand why mental illness and gun violence are connected. Price (2011) offers an explanation: that mental disability is constructed as the cause of violence in an "effort to attach some rational cause to the killings" (p. 146). In an analysis of media articles about shooters, Price (2011) finds that many take any evidence related to MH, even studying MH (p. 147), to construct a history that implies

[4] Price (2011) uses the term mental disability. While my dissertation generally uses "mental illness" or "mental health concerns," I am using her term here to discuss her work.

that the shooter had a mental disability. However, as she finds, media articles linking gun violence and mental illness usually leave the action of diagnosis to the reader. Per the Health Insurance Portability and Accountability Act (HIPAA), medical records are private[5]. Instead, as Price (2011) notes, "The interstices between these juxtaposed pieces of information encourage the reader to draw stereotypical conclusions about madness, violence, and academic discourses" (p. 149). Deviant behavior is used to support the argument that the person was mentally ill, which provides an explanation for the person's other deviant behavior.

After the MSDHS shooting, a commission authorized by the Florida legislature published a 439-page report detailing the events of the incident, as well as a review of previous school shootings. The report's incident summary makes similar moves to the ones that Price (2011) identifies in media analyses: the shooter is portrayed as a "troubled child" who "displayed aggressive and violent tendencies as early as 3 years old" (p. 7). The paragraph closes by noting that the shooter "refused further [MH] services" at age 18" (p. 7). This paragraph is the second after the preface and the content contrasts with later information in the report. Later, the report notes that according to the National Institute for Mental Health (NIMH), "most acts of violence are not committed by those with serious mental illness" (p. 15). Despite this evidence-based note in a later paragraph, the early description of the shooter constructs them as a person who was mentally ill and whose "violent tendencies" were present from early childhood. These markers of deviance explain a deviant individual, helping the MSD commission justify the claim that "another key element of school safety is ensuring mental and behavioral issues are properly

[5] In the case of the MSDHS shooting, the shooter's medical records were reviewed by the MSDHS commission. They found that the shooter was "identified as having behavioral health issues as early as three years old; however, [the shooter] was never diagnosed with a serious mental illness" (p. 267).

addressed" (p. 2). Published after SB 7026 was signed into law, these sections of the MSD commission report support a purported link between gun violence and mental illness.

As incidents of gun violence have grown more common, media coverage of these incidents has changed. While Price (2011) finds that many media articles perpetuate a connection between mental disability and violence, more recent media articles published after the MSDHS shooting contest the purported link between gun violence and mental illness. Two days after the MSDHS shooting, the *New York Times* published an article moderating misconceptions about mental illness and violence. The article reports that "roughly half of Americans either believe that failing to identify people with mental health problems is the primary cause of gun violence or that addressing mental health issues would be a major deterrent" (2018, n.p.). The source of this information is a 2015 poll from *The Washington Post* that finds that 63 percent of Americans believe that mass shootings were a reflection of MH problems, versus 23 percent of respondents who believed that mass shootings were a reflection of gun control law. The article goes on to note that "That conclusion is not shared by experts or widely accepted research" (2018, n.p.). Additional media articles published content aligned with the *New York Times*. *PBS News Hour*, for example, draws on Associated Press news published five days after the MSDHS shooting by stating that "Frustration is mounting in the medical community as the Trump administration again points to mental illness in response to yet another mass shooting" (2018, n.p.). In the piece, multiple medical experts reiterate that most people with mental illnesses are not violent. Instead, as the article concludes after interviews with those medical experts, "the administration is ignoring the real problem — easy access to guns, particularly the kind of high-powered highly lethal assault weapons used in many of the most recent mass shootings" (2018, n.p). An article from *NBC News*, first published in 2017, then updated three days after the MDSHS shooting,

corroborates this theme: “the Trump administration and many Republicans have said that the best way to end the seemingly constant stream of mass shootings is by combating mental illness” but that “while some think it a reasonable idea, mental health and mass shooting experts aren't so sure” (2018, n.p.). These media articles show a different type of narrative emerging from incidents of school violence: that though some, predominantly conservative pundits, are pointing to mental illness as a cause for acts of violence, most people with mental illnesses are not violent.

Media articles themselves corroborate the existence of this trend. An *ABC News* article, published in 2019, notes that “A predictable pattern emerges each time there is a mass shooting in this country: the initial shock and search for answers gives way to a debate over guns and mental health care” (2019, n.p.). The author interviews the mother of a child with schizophrenia who is worried that the connection between violence and mental illness will cause additional stigma for individuals with mental illnesses. A 2019 editorial from *TIME* calls the connection between mental illness “illusory truth effect,” stating that “So many people have said that mental illness is related to mass shootings from disparate political beliefs, for so many decades, and so many different times that it’s easy to just accept the premise without questioning it” (2019, n.p). The *TIME* editorial also notes that this effect can increase MH stigma. An article from the *New Yorker*, published one day after the MSDHS shooting, follows the narrative arc of news coverage of a mass shooting. As the author contends, at the end of the narrative arc is the belief that “…somehow, if the authorities had only been aware of worrisome signs about a future mass shooter’s mental health, the tragedy could have been averted” (2018, n.p.). Articles in this vein generally present quotes from MH experts stating that access to MH care should be expanded but that focusing on mental illness as the cause of violence is likely to increase MH stigma.

Anti-stigma Campaigns

MH stigma is a barrier to MH treatment access that anti-stigma campaigns attempt to redress through MH education. Stigma is often presented as an individual shame that individuals with MH concerns have, a shame that prevents them from seeking treatment. For example, an advocacy brief from the *American Psychological Association* (APA) writes that the organization "supports efforts to eradicate mental illness stigma through public education campaigns and strongly discourages the use of inaccurate and harmful rhetoric that blames America's gun violence problem soley [sic] on mental illness" (2019, n.p.). Here, mental illness stigma is an entity that can be eliminated through education. Similarly, Knoll and Annas (2016), in a book published by the APA, explain that "Fear, anxiety, and the need to find quick and clear-cut solutions lead to common but mistaken beliefs that reinforce the stigmatization of individuals with mental illness" (p. 94). So too, the authors recommend education as a means of reducing stigma (p. 98). Stigma, portrayed in these articles, is something that can be increased through the incorrect claim that mental illness is linked to violence. MH education is presented as the answer to MH stigma, to eliminate these misconceptions about mental illness and violence, as well as encourage those with mental illness to seek MH treatment. These beliefs about MH stigma inform many anti-stigma campaigns.

Anti-stigma campaigns emphasize the role of individuals in reducing mental illness stigma. The National Alliance on Mental Illness (NAMI) states that "stigma causes people to feel ashamed for something that is out of their control" (2017, n.p.). To fight stigma, the NAMI recommends talking about mental health, education, avoiding problematic language about mental illness, reminding individuals that mental illness is a disease[6], being compassionate, emphasizing

[6] This statement is indicative of the brain-disease model of mental illness and substance abuse.

empowerment, calling out stereotyping, and avoiding self-stigma. These individual actions present mental health stigma as a shame visited upon individuals with mental illnesses or harbored by individuals with mental illnesses. The cause of stigma, according to this and other anti-stigma campaigns, rests in stereotypes about mental illness. Blaming stereotypes is simple. As Feldman (2018) contends, "It's not just the public who stigmatizes mental illness. People with mental health issues can internalize these toxic attitudes, developing self-stigma. When people with mental illness are afraid of being judged by others or hold such attitudes themselves, this can discourage them from seeking care" (2018, n.p.). The *Mayo Clinic* calls these judgements "false beliefs," representative of individual prejudice, writing that "stigma is when someone views you in a negative way because you have a distinguishing characteristic or personal trait that's thought to be, or actually is, a disadvantage (a negative stereotype). Unfortunately, negative attitudes and beliefs toward people who have a mental health condition are common" (2017, n.p.). According to these and other sources, stigma is caused by stereotypes about mental illness held by the public. If those stereotypes can be shown to be false, mental illness can be de-stigmatized. More education is usually suggested to do the work of de-stigmatization, evoking the information-deficit model[7].

In Florida, MH legislation often links mental illness and violence through its terms of involuntary examination and the means by which involuntary examination is carried out. In this next section, I overview public concerns associated with the Florida MH Act, or Chapter 394, and its use of law enforcement officers to involuntarily transfer individuals to protective custody,

[7] The information deficit model, suggesting that misinformed public opinions are due to ignorance, and that more education and information will cause the public opinion to shift, has been widely discredited. In McDivitt's (2011) thesis on climate change communication, for example, the author notes that "the information-deficit model is dead" at multiple points, referring to the belief that if members of the public are better educated about climate change, they will change their behaviors. And Corrigan & Penn (1999), writing about mental illness stigma, recap social science research that finds that once formed, knowledge structures are difficult to dismantle.

involuntary evaluation, and treatment. This section focuses particularly on involuntary protective custody, involuntary examination and treatment of children due to the intersection of attitudes on mental illness and violence with this project.

The Florida MH Act and Involuntary Examination

Enacted in 1971, the Florida MH Act (often called the Baker Act) establishes the rights of individuals with mental illness and substance abuse concerns. For example, the MH Act ensures that these individuals possess "individual dignity and human rights" (394.453). The MH Act supports these rights by mandating guidelines for MH treatment and the professionals allowed to administer MH treatment, restricting the use of seclusion and restraints for individuals, and recognizing the need for additional research to address mental illness and substance abuse concerns. In Florida, the best-known portions of the MH Act are the sections on involuntary examination of individuals believed to represent a danger to themselves or others. In general, both the Florida MH Act and the Marchman Act use the term "protective custody" to describe law enforcement control of a person believed to have mental health or substance abuse concerns who meets the requirements for protective custody. The term "involuntary examination" is used to describe such an individual's transfer to a receiving facility for such an evaluation, with "involuntary admission" used to describe such an individual's commitment within a treatment facility. "Involuntary commitment" is used in the MH Act only to describe the commitment of the individuals termed "sexually violent predators" under part V of the Act; the term is not used in the Marchman Act. The term "Baker Acted" has become everyday vernacular to describe these practices. Below, the Google N-gram and Google Trends charts show increasing popularity of the term, suggesting increased public awareness of the Baker Act as well.

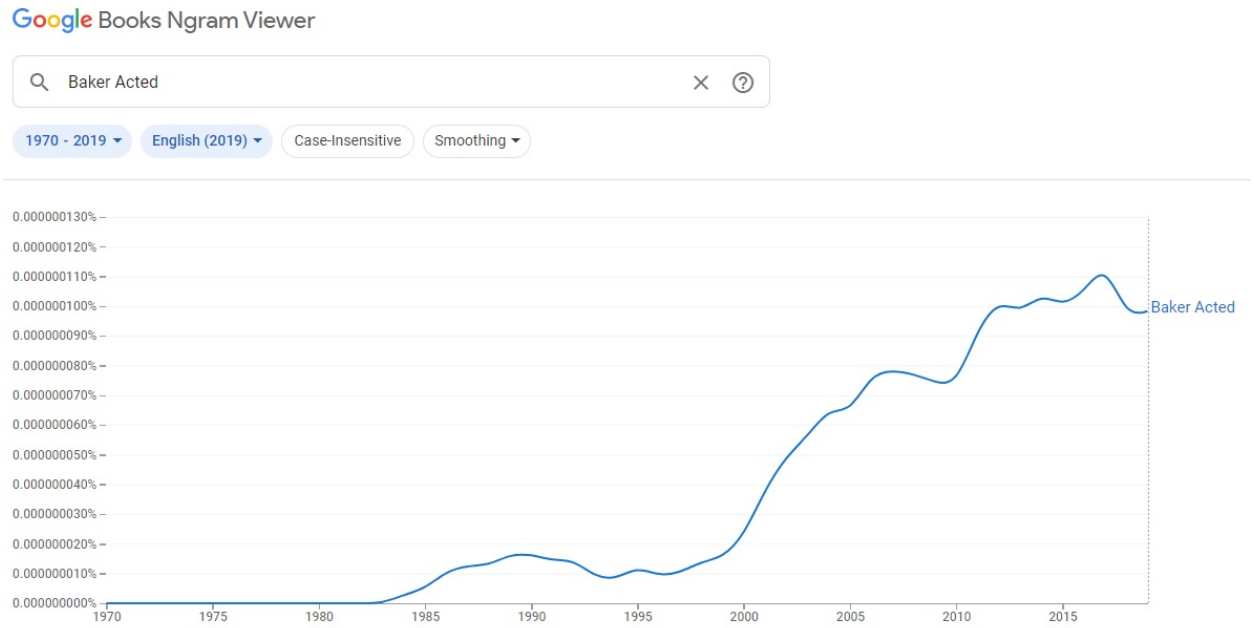

Figure 1: Google N-grams Graph of "Baker Acted" as Verb, 1970-2019

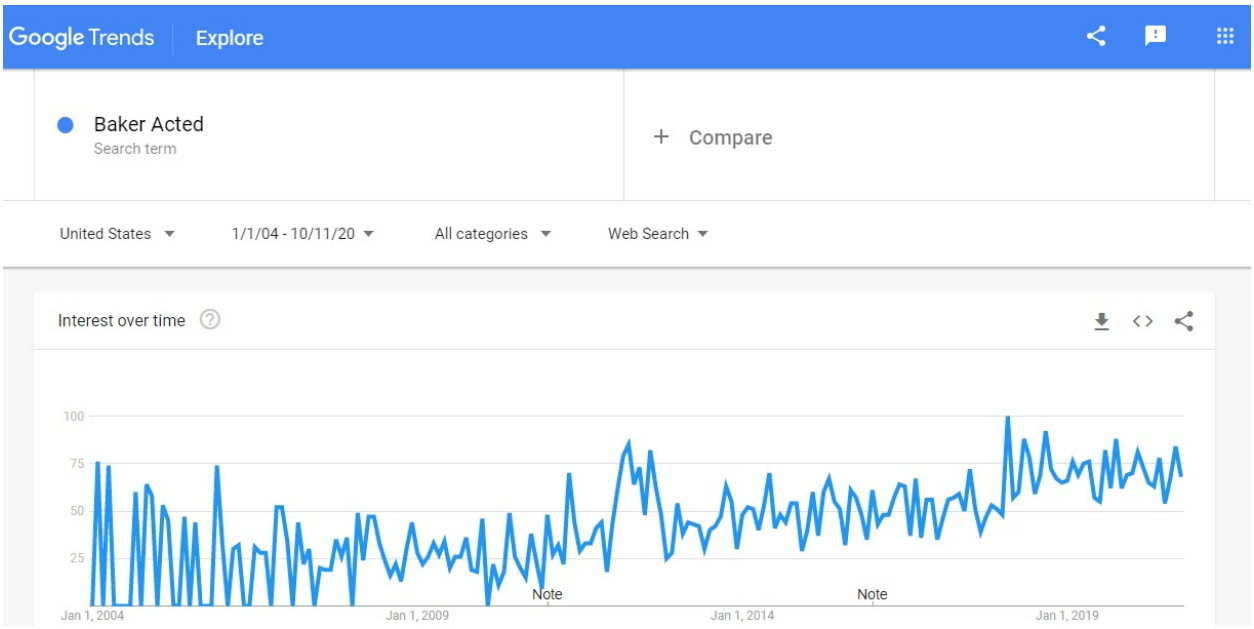

Figure 2: Google Trends Graph of "Baker Acted," 2004-2019

According to Google Trends, the following terms and topics are associated with "Baker Acted" searches: Florida, Florida Mental Health Act, Mental health, Mental disorder, Firearm, Person, Police, Psychiatric hospital, Concealed carry, Arrest, Suicide, Bipolar disorder, Psychosis, and Public records. These terms hint at the connections that the MH Act makes between involuntary examination and topics of public concern.

Involuntary examination under the Florida MH Act is indeed associated with mental health, firearms, police, psychiatric hospitals, arrest, suicide, and to some extent, public records, because police departments publish data about calls for service, including whether a Baker Act was performed. While the Florida MH Act is most commonly associated with mental health, it may sometimes apply to individuals with substance abuse concerns, though substance abuse concerns are more explicitly addressed in the Florida Marchman Act, sometimes known as Chapter 397. The interplay between the MH Act and the Marchman Act allows for the involuntary commitment of individuals; law enforcement is generally responsible for deciding to take an individual into protective custody and then transfer the individual to a facility for involuntary examination. As the Florida Department of Children and Families advises, "Under Marchman Act Protective Custody initiated by law enforcement, the officer is only permitted to take the person to home, hospital, or detox with the person's consent, whichever the officer believes is the most appropriate setting for the person. If the person doesn't give such consent, it is limited to hospital or detox, unless the person is taken to jail" (p. 3). While the Marchman Act (2019) does include references to criminal proceedings due to drug use, it specifies that protective custody is "detention is not to be considered an arrest for any purpose, and no entry or other record may be made to indicate that the person has been detained or charged with any crime" (397.6772). [1] Both the MH Act and the Marchman Act limit transfers to protective

custody to law enforcement officers, designated by statute 943.10 as “any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency.” Still, the function of law enforcement officers in carrying out protective custody orders, and the role of treatment facilities in detaining individuals under involuntary status, are two areas of public concern.

In particular, Florida’s MH Act has received criticism for its treatment of children, with public attention focusing on the increasing number of minors involuntarily examined under the legislation. A state task force (2017) appointed to study the issue notes that between July 1, 2015, and June 30, 2016, a total of 32,475 children (minors under the age of 18) were given involuntary examinations (p. 1). The task force report notes that in the preceding five years, involuntary examinations of minors have increased by approximately 49 percent, while the population has only increased by approximately 5 percent. Thus, the task force was appointed to "research the root causes of any trends in such involuntary examinations" and "identify recommendations for encouraging alternatives to and eliminating inappropriate initiations of such examinations" (p. 1). Later in the report, the task force finds that there are no specific root causes of involuntary examinations because too many contextual factors impact whether a minor is involuntarily committed for examination. However, the task force does find that involuntarily

examinations are precipitated by a confluence of conditions, including "Social Stressors and Risk Factors," "Mental Health Conditions Among Children and Teens," "Limited Availability of and Access to a Continuum of Services and Supports," and "Investment in the Lives of Children, Youth, and Families," and "Impact of Positive Initiatives on Increase in Involuntary Examination of Minors," (pp. 21-25). The report particularly notes the lack of funding for MH care in Florida; at the time of publication, state funding for children's MH care is ranked between 48 and 50 out of 52 states and territories (p. 13). The report closes by specifying legislative revisions and requests for MH appropriations to the Florida MH Act. While the task force recommends that the Florida MH Act be revised in several places to add specifications to the criteria for children's involuntary examination, some public sources find fault with the Florida MH Act itself.

Public media articles indicate discontent with the protective custody and detainment of children under the MH Act. In many cases, media note the young ages of children being detained. Interviewed in response to the Baker Act Task Force's (2017) report and finding that involuntary examinations of children under the age of 13 were up 17%, a task force member claims that the increase is because "We're asking adults to pay attention to more and more things and the more they pay attention to those things, I think the more children are Baker Acted" (LaGrone, 2019). The claim that increased awareness of children's MH leads to more involuntary examinations of children is contested; some organizations find fault with the law itself. As a *Tampa Bay Times* investigation (Anton & Pendygraft, 2019) finds, "officers hospitalized children who had a meltdown, refused an order or drew a troubling picture. Some kids vaguely threatened to hurt themselves. Other children exhibited behavior that was typical for their development disabilities and identified in their federal education plans" (n.p.). The investigation associates the overuse of taking children into protective custody with law

enforcement MH training and with school administrators overusing the Act to remove children from school. Schools are highly associated with use of the MH Act. The task force (2017) released a graph of rising involuntary examinations of children, showing drops during traditional summer months (p. 13).

In a report[8] on police presence in schools sponsored by the Florida ACLU, Equality Florida, Florida Social Justice in Schools Project, Southern Poverty Law Center, and the League of Women Voters of Florida, Morton et al. (n.d.) note the fiscal and social costs of police presence in Florida schools. The report finds fault with the 2018 Marjory Stoneman Douglas Commission, enacted by the state legislature to make recommendations about improving school safety. Critiquing the commission's composition, Morton et al. (n.d.) note that the MSD Commission was comprised of many law enforcement officers, without representation from teachers, students, student organizations, people of color, or community organizations (p. 11). This note suggests that the MSD Commission's findings are focused on police presence, a conclusion generally borne out in my analysis of the report in the next chapter. While the state Department of Education objected to the findings of the report (see footnote 4), this finding at least seems supported by public documents produced by the MSD Commission itself. According to the Commission's initial report (2019), the Commission included seven appointees, three of whom include law enforcement training in their report biographies. Morton et al. (n.d.) assert that the MH Act is being increasingly used to involuntarily place into protective custody children "who make jokes, act out, exhibit normal manifestations of a known disability, or express

[8] In a statement to *ABC Action News* (McGivern, 2020) about this report, the Florida Department of Education rebuts the findings of this report, claiming in part that "This 'study' clearly has nothing to do with school safety, but rather politicizing the safety of Florida's students. At the end of the day, our priority is and will remain the safety and security of our students and it is outrageous that the authors of this report are using Florida students as a political gambling chip. Frankly, this report is a reckless and thoughtless commentary that could endanger our students if locally elected officials were to mistake it for objective research."

ordinary sadness" (p. 15). The MH Act requires extensive training for social workers and psychologists to initiate involuntary examinations. In contrast to this, the report claims that "there are no prerequisites for police officers to handcuff a child and have them committed" (p. 15), though as discussed in a previous paragraph, the MH Act only uses the word "committed" in reference to a person who has also been involved in criminal behavior and the Marchman Act does not use the word "committed" at all. The concerns submitted in this report exemplify advocates' concerns that the Florida MH Act is associated with police protective custody and especially police protective custody of children.

While the MH Act has been revised multiple times since its codification in 1971, some sources have called for additional reforms to protect individuals further from protective custody, involuntary examination, and involuntary status. As Shapiro (2020) writes in an *Orlando Sentinel* commentary, one of the problems with the MH Act is the complicated process for admitting children to voluntary treatment. A judge has to hear from both the child and the parent and then make a decision about admittance to voluntary treatment. Due to this process, as Shapiro (2020) notes, a "admissions for minors are almost always involuntary" and almost 70% of involuntary admissions are initiated by law enforcement officers. The use of law enforcement officers, who are allowed to use restraints including handcuffs on children in protective custody under the MH Act, contributes materially to the misconnection between mental illness and violence. Revisions to the Florida MH Act might address these concerns.

In these previous two sections, I explored the misconnection between mental illness and violence through media and advocacy group reporting. I then explored the presence of this misconnection within the Florida MH Act's authorization of the involuntary admission to MH treatment of minors, frequently by law enforcement officers. In this next section, I overview the

development of Florida MH legislation to show how these concerns came into existence. I find that the misconnection between mental illness and risk of violence evokes concerns begun during the process of deinstitutionalization. Combined with context on the increased involuntary examinations of children in this way, my analysis shows that the Florida MH Act created the conditions under which children with mental illnesses may be viewed as risks due to their perceived dangerousness.

Historical Studies and Medical Discourse

For rhetorical scholars, historical studies on mental illness have focused on asylums and the impact of institutionalization on attitudes toward MH. These studies show how mental illness is constructed within documents, such as case files and patient writing. Hanganu-Bresch & Berkenkotter (2019), for example, trace the rhetoric of psychiatry through asylums, showing the discursive factors that contributed to the beginnings of deinstitutionalization. Takayoshi (2020) also finds factors that contributed to the decline of asylums through a study of women's asylum memoirs. Indeed, centering on the discursive construction of mental illness within asylums is a frequently studied topic in disability studies as well. Stuckey (2011) contrasts the letters of asylum residents against the medical discourses of their environment, reading silence into the content allowed within the letters. Moreover, von Bernuth (2006) examines the historical conditions which led to the institutionalization of individuals with mental illnesses, noting the emergence of asylums in response to perceived "normalcy" and deviance. These historical studies seek to redress the harms that medicalized discourse has perpetrated on the identities of individuals with mental illnesses by highlighting documents that exemplify the individual's voice.

The emerging field of mad studies has sometimes taken issue with the approach to privileging the voices of individuals with mental illness. Russo and Beresford (2014) term these accounts of individuals with mental illnesses counternarratives and position them as an alternative perspective to the psychiatric discourses of mental illness. Though this scholarship is presented in opposition to dominant discourses of mental illness, Russo and Beresford (2014) write that, "The fact that these encounters with interested academics happen outside treatment, and that the new interpretation usually makes more sense than the psychiatric one, hardly prevents us from feeling like somebody's case again" (pp. 153-154). Using the idea of counternarrative to describe academic attempts to engage with individual voices of mental illness, the authors note that considering individuals with mental illness in opposition to dominant discourses of psychiatry only reinforces these binaries and perpetuates epistemic injustices[9] (p. 156). In response to these injustices, Beresford (2018) argues against bio-medicalized understandings of disability, "[encouraging] appreciation of how we can be made mad by society and our circumstances in it" (p. 1340). Bio-medicalized explanations of mental illness represent an incomplete understanding of disability, though I will note that many rhetorical scholars of health and medicine utilize a bio-psycho-social model of illness rather than Beresford's predominantly social one.

In doing this work, research in disability studies has noted that medical discourse constructs the conditions under which individuals with mental illnesses are deemed non-normative. Hawkes (2019) analyzes a reference guide about mental health resources on a college campus and notes a "conflict in the rhetoric of the Guide that nicely reflects a historical

[9] Among these epistemic injustices, Beresford (2018) notes, is the usage of terms like "mental illness" or "mental health" (p. 1337). However, as my own work engages with the documents that construct and maintain these epistemic injustices, I use "mental illness" and "mental health," as they are the terms used in the documents I study.

dichotomy of care and fear that has long governed our uncertain response to mental illness" (p. 163). Readers of the guide are directed to decide whether a behavior is "uncharacteristic," "disruptive," or "dangerous," and then respond, indicative of a "tradition of psychiatry that reduces complex individual experiences to symptoms" (p. 164). As Hawkes notes, it is not helpful that the guide associate "dangerous" student behavior with mental illness[10] and provides the number for campus security as a resource. The rhetorical construction of mental illness through documentation impacts disclosure. Irvine (2011) examines disclosure of mental health conditions in the workplace, finding two impacts: that individuals with mental health conditions do not replicate medical language when describing their conditions and that many individuals with mental health conditions choose not to discuss their conditions at all. Similarly, Venville et al., (2014) examined students' preference to disclose mental illness, concluding that many students viewed mental illness disclosure as a cost-benefit analysis (p. 797). Against some studies suggesting that mental illness disclosure may worsen student outcomes due to discrimination, and documentation that associates mental illness with dangerous behavior, individuals with mental illnesses have reasons to avoid disclosure.

Understanding that documentation may associate mental illness with dangerous behavior, in this project, I study documentation in search of this connection. Given the connection between involuntary examination in the state of Florida, the treatment of children under the state's MH act, and the resulting association between mental illness and gun violence, I analyze mental health documentation in the United States from the National Mental Health Act, to the Community Mental Health Act, to the creation of the Florida MH Act. Within this content analysis, I note critiques of deinstitutionalization that have contributed to the misconception that

[10] As the author notes, the most common mental illness on campus is depression, a disorder that is not usually associated with violence (p. 166).

individuals' nonnormative behavior is dangerous and should result in involuntary examination under state law. The slippage around the term "dangerousness" in the law results in increasing involuntary examinations, especially as the state expands its conception of the legal term *parens patriae*, or the authority of the government to assume responsibility as the legal protector of citizens unable to protect themselves, to encompass behavior that may lead to neglect as dangerous.

Deinstitutionalization in the United States

As introduced in the previous chapter, deinstitutionalization occurred throughout the United States from the 1950s onward, the result of multiple factors including newfound psychiatric medications, public burden of individuals with mental illnesses, and public outrage in response to conditions of care in mental institutions. Deinstitutionalization is widely credited as a successful shift in this country, but some detractors remain. Deinstitutionalization is commonly blamed for the high prevalence of mental illness in jails and among the homeless population (Flory & Friedrich, 1999). For some individuals with mental illness, community-based treatments (e.g., brief hospital stays, medication, and out-patient services) are not adequate to their needs. Deinstitutionalization has meant that individuals in this group are repeatedly hospitalized, subject to arrest, and may experience homelessness if they lack the connections to obtain employment or housing.

The movement to deinstitutionalize individuals with mental illness or disabilities was codified in 1946 with the creation of the National Mental Health Act. The National Mental Health Act created funding for the National Institute of Mental Health (NIMH) and explained the new federal priorities to evaluate and treat mental illnesses without institutionalization if

possible. Treatment consisted of new psychiatric medications, including chlorpromazine[11], reports Torrey (1997). Especially after the creation of federal funding for these types of MH treatment with Medicaid and Medicare, states began to reduce MH spending by moving individuals with mental illnesses out of psychiatric facilities and then closing those facilities. As Torrey (1997) states, "In 1955, there were 558,239 severely mentally ill patients in the nation's public psychiatric hospitals. In 1994, this number had been reduced by 486,620 patients, to 71,619." However, Torrey (1997) calculates the population increase between 1955 and 1994, noting that "If there had been the same proportion of patients per population in public mental hospitals in 1994 as there had been in 1955, the patients would have totaled 885,010. The true magnitude of deinstitutionalization, then, is the difference between 885,010 and 71,619" (n.p.). Many of these individuals had been diagnosed with schizophrenia or other disorders consistent with what Torrey (1997) calls "brain dysfunction." (n.p.). As a consequence, Torrey (1997) notes, and many critiques of deinstitutionalization argue similarly, "deinstitutionalization has helped create the mental illness crisis by discharging people from public psychiatric hospitals without ensuring that they received the medication and rehabilitation services necessary for them to live successfully in the community," (n.p.). These critiques argue that deinstitutionalization resulted in a number of individuals with mental illnesses being released into the community without adequate MH care.

One of the motivators for the systemic MH reform were multiple publications about abuse of residents committed within psychiatric facilities. In 1946, *Life* magazine's Albert Maisel published his notable article "Bedlam, 1946," detailing the abuse suffered by many patients at the Philadelphia State Hospital near Philadelphia, Pennsylvania. As Maisel (1946)

[11] Chlorpromazine is an anti-psychotic often used to treat schizophrenia and manic-depressive disorder.

writes, "Through public neglect and legislative penny-pinching, state after state has allowed its institutions for the care and cure of the mentally sick to degenerate into little more than concentration camps on the Belsen pattern" (p. 102). Among the abuses the article detailed were the use of constraints, overcrowding, understaffing, and the rampant spread of diseases like tuberculosis, pneumonia, and hepatitis[12]. Maisel's (1946) report relies on graphic photos of victims of abuse in psychiatric facilities, as well as narratives from attendants and orderlies, many of whom, Maisel notes, were conscientious objectors from the Selective Service Act (p. 103). These narratives informed the scope of the article, which begins at the Pennsylvania facility but also discusses abuses committed in psychiatric facilities in multiple states. The article closes by articulating a familiar argument—that by paying for pharmacological treatment for individuals with mental illnesses, "the state receives a high proportion of useful, economically productive citizens" (p. 118). This influential article was used to draw public support[13] for MH reform, as journalist Robert Whittaker (n.d.) notes.

In 1963, the Community Mental Health Act[14] (CMHA)was enacted to further deinstitutionalize MH care by prioritizing the federal funding of community-based MH care facilities, which emphasized out-patient treatment. Then-president Kennedy supported the Act, stating that "When [the Act is] carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining

[12] Children committed to Willowbrook State School from approximately 1950-1970 in Staten Island, New York, were intentionally infected with hepatitis by researchers attempting to develop a treatment for the disease. Willowbrook State School is a common case study in bioethics, e.g. Kumar, 2016; Education Development Center, 2009.

[13] John F. Kennedy also promoted MH reform on behalf of his sister Rosemary Kennedy, on whom a lobotomy was performed in 1941. The procedure permanently impaired Rosemary Kennedy's mental state; she was institutionalized with limited contact to her family members for the next 28 years.

[14] While known as the Community Mental Health Act of 1963, the longform title is "Mental R*********n Facilities and Community Mental Health Centers Act of 1963" (Public Law 88-164).

patients in an institution to wither away" (1965, qtd in SAMHSA, 2016). The Act appropriated millions of dollars to fund the construction of MH research facilities to "assist in finding the causes, and means of prevention, of mental r**********, or in finding means of ameliorating the effects of mental r**********" (p. 282). Importantly, the CMHA laid the groundwork for state MH plans. Among the requirements that states must follow are:

> 1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;
>
> 2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;
>
> 3) provide for the designation of a State advisory council which shall include representatives of State agencies concerned with planning, operation, or utilization of facilities for the mentally retarded and of government organizations or groups concerned with education, employment, rehabilitation, welfare, and health, and including representatives of consumers of the services provided by such facilities;
>
> 4) set forth a program for construction of facilities for the mentally r******d (A) which is based on a statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed under section 133(1); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 133(4); (p. 287)

These requirements formed the basis of state level MH plans that began to be developed in the 1960s in response to deinstitutionalization initiatives. Deinstitutionalization further coincided with the establishment of the federal Social Security Act amendments of 1965, which established Medicare and Medicaid.

The CMHA led to approximately a 90 percent reduction in state psychiatric facilities after its passage. In subsequent years, Congressional funding for the Act declined as licensing and facility requirements for community-based MH programs grew. While the Carter administration succeeded in passing Mental Health Systems Act of 1980 to support additional funding for MH care, the Reagan[15] administration repealed the Act (Sharfstein, 2000). As the National Council of Behavioral Health (2020) sums up the impact of the CMHA, "Community-based behavioral healthcare is delivered by a mix of government and county-operated organizations, as well as private nonprofit and for-profit organizations. These mental health and addiction services are funded by a patchwork of sources, including Medicaid; Medicare; county, state, and federal programs; private insurance; and self-pays" (n.p.). States were left to navigate this patchwork in their own MH legislation.

The CMHA and Florida MH Research

In 1967, the CMHA provided 16 million dollars to the University of South Florida to create an MH research facility. Commonly known as the Florida Mental Health Institute (FMHI), the institute's purpose was to "serve as a bridge between university-based research and communities facing a variety of problems related to mental illness" ("History of the Institute," 2020). Work in the 1970s included construction of the institute. For example, a July 30, 1971 memo from the

[15] As Torrey (2013) claims about this repeal, when "President Ronald Reagan finally block-granted federal CMHC funds to the states in 1981, he was not killing the program. He was disposing of the corpse" (n.p.). Note that this article incorrectly implies that many individuals with mental illness are violent.

institute's archives notes that funding for administration at the "Florida Institute" will not begin until July 1972. In the 1980s, the mission of the FMHI shifted to "[provide] training, education, and research in support of the state's mental health service system," (History of the Institute, 2020). The mission continued to shift in later decades, with the FMHI serving in 1999 to advise the state legislature on mental health and substance abuse. At the time, identified state MH and substance abuse needs were:

- Universal assessment in order to identify individuals with mental health and addictive disorders to facilitate their entry into treatment;
- Improved access to culturally relevant services that promotes persons seeking care;
- Integrated, high quality care, including evidence-based treatments that promote recovery from mental and addictive disorders;
- Reducing stigma;
- Appropriate funding levels;
- Outcomes tracking to ensure that mental health and substance abuse services are achieving their goals, and to promote continual improvement in delivery and effectiveness.

Central to these outcomes tracking natives were data on criminal justice and homelessness, deemed "system failure" in an archival document visualizing the "Defacto [sic] MHSA System." Although founded directly by the CMHA, the FMHI appears to have had little impact on the creation of the Florida MH Act four years later.

Dispersing into Florida via the Florida Mental Health Act[16]

According to the Florida Court Education Council, Florida MH law[17] existed since 1874 (Lenderman & Cadigan, 2016). The Florida Department of Children and Families (DCF) echoes this information, adding that before the MH Act was enacted, "a person could be placed in a state hospital if three people signed affidavits and secured the approval of a county judge" (p. 1). Moreover, "any destitute person with mental illness [was] committed to the sheriff for safekeeping until transferred to the hospital" (p. 1). The Florida DCF also claims that the Florida MH Act was "landmark legislation" for its emphasis on deinstitutionalization and psychiatric medications, though these emphases were made years earlier via federal law, as the last section shows. In 1970, in preparation for the coming legislation, the Florida Legislature enacted chapter 131 which includes a number of changes to the law, including:

- providing rights of patients and habeas corpus;
- providing procedures for admission and discharge of patients;
- providing for receiving and treatment facilities;
- prescribing procedure for evaluation of patients in involuntary admissions and for court hearings;
- validating prior hospitalizations and providing for annual review of patients (p. 345).

A number of reforms were also enacted upon Chapter 394 itself, including the establishment of the MH act under the authority of the Department of Children and Families, aligning with the requirements of the CMHA.

[16] While in later chapters I refer to the Florida MH Act as Chapter 394, in 1971, Chapter 131 drew together multiple statutes to reform Chapter 394. To avoid mistitling these statutes, I am referring to these statutes as the Florida MH Act, which is allowed by Chapter 131 (p. 346).

With the power to commit individuals with mental illnesses involuntarily, the Florida MH Act exemplifies *parens patriae*. As an executive summary of the Florida MH Act's effects commissioned by the Florida courts (1999) states, "The state is the only entity with the authority to restrict a person's liberty. Involuntary mental health examination and placement involve a balancing of individual rights with the state's *parens patriae* authority and police powers" (n.p.). A report for understanding legal cases relevant to Florida's involuntary treatment statute references U.S. Supreme Court case *O'Connor v. Donaldson* (1975), which recognized the rights of individuals with mental illness but who were not considered dangerous to "not disqualify a person from preferring his [sic] home to the comforts of an institution" (qtd in Committee on Children, Families, and Elder Affairs, 2008). The report notes debate surrounding the designation of dangerousness as a qualification of involuntary treatment, commenting that "in the opinion of some commentators, the view that dangerousness is the exclusive justification for civil commitment ignores the state's legitimate *parens patriae* power" (2008, p. 6). The report closes by recommending that the Florida MH Act be amended to require involuntary admission to individuals who show a need for treatment. While these recommendations have not been implemented, reports show that increasing numbers of Florida residents (adjusted for population increase) are being transferred to protective custody and admitted for involuntary evaluation.

These actions can be traced back to the critiques of deinstitutionalization; among them the belief dangerous individuals with mental illnesses were being moved into the community. While the deinstitutionalization movement is largely perceived to have improved individuals with mental illnesses' quality of life, perceptions of it are that the movement "[shifted] burdens" from the federal government onto the community and the families of individuals with mental illnesses (Sutherland, 2015). Under the perception that individuals with mental illnesses

originally belonged in psychiatric facilities, involuntary evaluation may be perceived as a form of correction. As Ben-Moshe (2020) writes about incarceration and disability, "When disability or madness is present, it is conceived of as a deficit, something in need of correction, medically/psychiatrically or by the correction industry, but not as a nuanced identity from which to understand how to live differently, including reevaluating responses to harm and difference" (n.p.). Ben-Moshe concludes that the deinstitutionalization process was an ideological movement[18] for changing ingrained responses to difference. However, because deinstitutionalization called for individuals with mental illnesses to live successfully within the community, the binary categories of disability remained the same. Ben-Moshe (2020) writes about this stasis, arguing that "the perspective changed from a focus on the environment (what would later be called the social model of disability) to a focus on the person (assimilation). ... By focusing on the individual with disability and their needs, though, these theories simultaneously entrenched a more deficit-driven individual model of disability" (p. 77). These binary models of disability provide an explanation for the increasing number of involuntary MH evaluations.

Under the Florida MH Act, treatment is evaluated by how effectively it has caused an individual to live "successfully" in the community (394.459). As disability studies scholars have noted, generally "success" is a measure determined by individuals with abled bodies or minds (Yergeau, 2018; Price, 2011). Under the deficit model of disability, those perceived to be unsuccessful at community life are further marked for debility[19]. Perception of unsuccessful life, as referenced by the Florida courts' recommendation to extend *parens patriae* powers, reinforce

[18] As explored earlier in this chapter, deinstitutionalization is largely considered to be due to financial, political, and ideological factors, but I agree with Ben-Moshe that public support was garnered through the journalistic exposes of conditions within psychiatric facilities.

[19] Puar (2017) calls this crip nationalism, where certain types of disabilities and stories about disabilities are emphasized.

an individual's perceived deviant status. Because designation of "dangerousness" is the only legal way to involuntarily transfer a person to protective custody, then involuntary examination, the designation is applied more frequently to individuals with mental illnesses. In the next section, I contrast this conclusion, that stigma is constructed and maintained by the state, with popular conceptions of MH stigma as a purely discursive construct.

Material Consequences of Stigma

Anti-stigma campaigns present MH stigma as a type of shaming that can be redressed through education. In this chapter, however, I have located stigma as a material-discursive concept, constructed and maintained through its material connections. These material connections include legal discourses that mark individuals with MH concerns as dangerous for the purpose of additional evaluation and surveillance[20]. Thinking through stigma as a material-discursive concept helps show why increasing MH education will fall short of addressing MH stigma. Gaudet (2019) illustrates the harm that comes from conceptualizing stigma as social construction in an analysis of mental illness awareness campaigns. Perceived to be a self-inflicted barrier to treatment access, mental illness can seemingly be avoided by "educating oneself about symptoms, self-diagnosing, and seeking medical expertise and treatment" (Gaudet, 2019, p. 167). This construction of mental illness avoidance as a personal choice further marginalizes these individuals because they are perceived as "being irresponsible and burdensome" (p. 167). This presentation of mental illness and its stigma is necessary because otherwise institutions would have to face the reality that, as Gaudet (2019) argues, "a stigmatized person is always dependent on the existence of a normative social body, while the normalcy of such a social body

[20] This discursive marking can be traced back to stigma's etymology: the physical branding of an individual based on their shameful status.

is reaffirmed through the categorization and othering of those who deviate from these rules" (p. 159). Institutions create and maintain these rules, marking individuals, materializing stigma.

When stigma is a material-discursive act anchored by institutions, stigma cannot be remediated by simply changing minds through education. The institutional documents that construct and maintain stigma must also be changed[21]. No amount of MH education is going to remove the student's name from the list or negate the list altogether. Secured by material documents, including policies, protocols, and systems, stigma continues against individuals with MH concerns. This stigma contributes to disability, as rhetorical scholars have found. Miller (2019) posits recuperative ethos as means of addressing stigma's rhetorical disability, noting that "social and cultural contexts [define] particular beliefs about individual autonomy, rationality, and what kinds of people with what kinds of bodies and minds fit (or don't fit) into common understandings of an able rhetor" (p. 66). Remediating the social construction of stigma means remediating all the connections that maintain the disability, a task that education alone cannot complete.

Conclusion

In Florida, MH legislation has authorized the involuntary evaluation of individuals on basis of their perceived dangerousness, a loosely defined term that has contributed to increased rates of involuntary evaluation across the state. The idea that individuals with MH concerns may be dangerous may be linked to critiques of deinstitutionalization, which held that dangerous individuals would be released from asylums into the community. Combined with the Florida MH Act's relative lack of instruction on addressing MH concerns in minors, the result is an

[21] In the next chapter, for example, I examine SB 7026, a piece of MH legislation that authorizes school district personnel to maintain a list of students whose behavior may pose a threat and to share this list of students with law enforcement. No amount of MH education is going to remove the student's name from the list or negate the list altogether.

environment that increasingly allows children to be perceived as dangerous based on their mental status. This perception results in increased children's transfers to protective custody for involuntary examination. As multiple media analyses of the issue note, involuntary protective custody and examination result in increased MH stigma, as the minor who is transferred to protective custody for involuntary examination is now perceived by both law enforcement, school district, and both local and state courts as a dangerous person. This label of "dangerousness" results in material consequences: school districts require children who have been transferred to protective custody for involuntary examination to conference with school administrators before they can return to school, children are required to report their previous involuntary examination upon registration in subsequent school districts, information about the children and their parents/guardians is shared with local law enforcement, and the state maintains a repository of data on these children.

Contrary to ideas of stigma as a purely discursive self-shame to be remediated through MH education, stigma is perpetuated by the law that allows institutionalization of children if they are deemed dangerous—a judgment made approximately 70 percent of the time by a law enforcement officer. Stigma is further constituted in the state agents (school districts, law enforcement, psychiatric receiving facilities) that reinforce the minor's "dangerous" status, and by the policies, protocols, and systems (school district MH plans, early warning systems, watchlists, data repositories) that justify the monitoring of these individuals. The situation provokes an interesting question for risk communication scholars: how can technical communicators eliminate risk? The necessity of this question is exemplified by an archival record (2000) from the Florida MH Institute about the reaction of neighborhood residents to a planned group home for individuals with MH concerns. In an email about the establishment of a

group home, citizen advocate Katharine C. Brandon writes that the neighborhood's views are "Same old NIMBY-not in MY backyard." Individuals—and particularly children—with MH concerns are deemed dangerous through legal slippage that allows their institutionalization.

In this chapter, I built the argument that remediating MH stigma requires attention to the policies, protocols, and systems that construct and maintain the disability of mental illness. I did this work through a content analysis of Florida's MH legislation, which in the wake of deinstitutionalization, detailed the state's means of addressing individuals with MH concerns. Combining this information with context about the Florida MH Act's current institutionalization of individuals with MH concerns, particularly of minors, I explained how institutionalization is allowed if an individual is deemed "dangerous." While the state of Florida may have disestablished asylums for individuals with MH concerns, the normalization of state evaluation, monitoring, and control over these individuals continues through MH legislation and contributes to MH stigma. In the next chapter, I show how dominant narratives about MH drive these misconceptions about mental illness. Using scholarship from rhetoric of health and medicine and from disability studies, I identify six dominant narratives about MH that normalize the state identification, evaluation, and monitoring of individuals with MH concerns. I then identify the presence of these dominant narratives within MH legislation.

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Chapter Three: Dominant Narratives and Mental Health Legislation

How does mental health legislation reinforce misconceptions about mental illness and increase stigma toward individuals who may need MH care? I study how such legislation may construct individuals with MH concerns as potential threats to public health and safety. When an individual is identified as a person with MH concerns, the individual is determined to need correction or cure. If the individual's MH concerns are not mitigated to the extent required by MH legislation, then MH legislation may mark individual's behavior as a potential threat. In some cases, MH legislation may require the institutionalization of individuals with MH concerns. Institutionalization confirms the misconception that people with MH concerns are potential threats to public health and safety, resulting in further MH stigma. In this way, MH legislation becomes a way that the state demonstrates control over individuals with MH concerns.

In this chapter, I identify dominant narratives about MH in two pieces of Florida MH legislation, SB 7026 and the Florida Mental Health Act, or Chapter 394. These dominant narratives interlock to construct individuals with MH concerns as potential threats to public safety who must be identified and treated in order to return to their previous abled state. To enact this analysis, I overview the current debate surrounding SB 7026 and Chapter 394, focusing particularly on the controversy over SB 7026's requirement to create a state-level data repository of students who have been referred for MH concerns accessible by school district personnel and law enforcement. Then I closely read SB 7026 and Chapter 394 to determine six dominant narratives about MH, utilizing scholarship from disability studies to show how these dominant narratives may cause harm to individuals with MH concerns. I draw these narratives together to

show how the state is positioning itself to identity individuals with MH concerns and control their access to treatment. The next chapter extends this analysis to find qualitative and quantitative connections between SB 7026 and Chapter 394 and Florida school districts' MH plans for identifying and threat-assessing students with MH concerns.

Florida MH Legislation: SB 7026 and Chapter 394

Enacted less than one month after 2018 MSDHS shooting, SB 7026, the first bill of the Marjory Stoneman Douglas High School Public Safety Act (MSDHSPSA) mandated changes on school campuses to protect school safety. Of these 181 required changes, 31 (17 percent) discuss Mental Health (MH) in some way. Indeed, whereas MH and MH related-actions (e.g. requiring that school districts and charter schools submit MH plans to the Department of Education each year) comprise 17 percent of SB 7026's mandated actions, changes relating to safety itself account for 7 percent of SB 7026's mandated actions. The differential suggests that MH represents a greater concern for public safety than state-level infrastructural changes, school safety specialists, district-level safety requirements, or school safety funding. Under SB 7026, MH mandates include changes to the Federal Firearms Prohibition, a federal law that restricts firearms access to any person under a risk protection (*ex parte*[22]) order, addressing student MH in school districts, funding for MH in schools, the creation of a MH plan per school district, and mandatory MH education for school district personnel and students (The Florida Senate, 2018). SB 7026 is a prominent and influential piece of Florida MH legislation, but it does not stand alone.

SB 7026 intersects with the powerful and well-established Chapter 394, the Florida Mental Health Act of 1971. Chapter 394 is commonly known by the title of its first part, the Baker Act. Though Chapter 394's most well-known aspect is that it allows for the involuntary

[22] "on behalf of." A judge may decide to restrict firearms access to individuals under an *ex parte* order without the individual's presence, though the individual is entitled to attend the hearing.

institutionalization and examination of individuals experiencing mental health concerns, Chapter 394 has five parts. This legislation addresses MH treatment programs (Part I), the Interstate Compact on MH[23] (Part II), child and adolescent MH services (Part III), community substance abuse and MH services (Part IV), and the involuntary civil commitment of "sexually violent predators" (Part V) (The Florida Senate, 2018). My analysis of this act extends to all five parts, so I refer to the act as Chapter 394 throughout this dissertation. Chapter 394 and SB 7026 converge at several points. When SB 7026 became a law in 2018, it mandated changes to Chapter 394, including new *ex parte* orders that restrict firearms access to individuals who may pose a threat on basis of MH condition. SB 7026 also replicates language from Chapter 394 when it addresses child and adolescent MH concerns. The replication of language from Chapter 394 to SB 7026 suggests that Chapter 394 is viewed as a valuable piece of MH legislation. SB 7026 and its progenitor Chapter 394 do not only overlap with each other. They are imbricated in a web of discourse surrounding MH concerns that focuses on gun control's relationship to school safety, which SB 7026 legislates to a lesser extent than MH.

SB 7026 is a primary focus of this dissertation, but its only one of the documents developed under the MSDHSPSA. The number and types of documents associated with the MSDHSPSA have proliferated since its creation in 2018. These include a "scathing" grand jury report examining SB 7026's initial implementation (Nicol, 2020) and SB 7030, a second, 30-page school safety package bill which clarifies the practices enacted in SB 7026 (The Florida Senate, 2018). A third bill which failed to pass, HB 7065, would have further refined SB 7026 by adding mental health training requirements for armed campus police and staff and made it more difficult to arrest children under the age of 7 (Mahoney, 2020). As the creation of SB 7030 and

[23] The Interstate Compact on Mental Health is an agreement between 45 states and the District of Columbia to provide MH treatment for individuals regardless of state residency (National Center for Interstate Compacts, 2019).

the failure of HB 7065 suggests, the MSDHSPSA has not been without controversy. March For Our Lives, a survivor/student-led alliance advocating for "sensible gun violence prevention policies that save lives" ("Mission & Story," 2020) critiqued legislators for not including the voices of students and parents within their decision-making (Southern Poverty Law Center, 2019). Many critiques of MSDHSPSA have centered on its requirement that school resource officers or police officers be stationed inside every school and suggest that mandatorily expanded police presence on campus may reify discrimination in school districts (Cain, 2020). The Southern Poverty Law Center (SPLC) is suing the MSDHS safety commission for enacting "…school policies that put marginalized students at risk and make schools less safe. … these policies will likely contribute not only to the school-to-prison pipeline, but also to the school-to-deportation pipeline" (Bennet, 2020). SPLC is fighting this legislation's potential to add to the discrimination historically over-policed groups of students already face. SB 7026's Guardian Program, an initiative to increase the number of and training required for armed personnel who either volunteer or are hired to address incidents of violence on campuses, has also been met with skepticism and concern over who is allowed to carry firearms around children (Luscombe, 2019). School resource officers and police are not the only armed presence in Florida's school; SB 7030 authorizes teachers to carry firearms in classrooms for the purpose of contributing to school safety (Holson, 2019). These examples suggest that the fiercest debates about the MSDHSPSA center on gun control and school safety, which, again, less than 7% of SB 7026 directly addresses. The 17% of SB 7026's text that addresses mental health concerns and related actions have also come under some scrutiny.

SB 7026 and its companion bill SB 7030 outline best practices for addressing MH in school districts and for composing annual MH plans in each district, funding guidance on

allocations to support MH-related initiatives approved by legislature, information on reporting student discipline incidents to the DOE, suicide prevention practices, and threat assessment practices by school district. These bills play an important role in evolving debates about the role of MH in school safety. For example, the MSDHSPSA's threat assessment tool was created to contain information including students' MH histories and social media accounts. This database has drawn suspicion and criticism. In its reflection on the threat assessment tool, the Aspen Tech Policy Hub (2019) noted that it "is nearly impossible to predict whether a particular student will incite gun violence as there are so few incidents of student shooters compared to the total number of students" (p. 5). As Aspen Tech Policy Hub's report warns those using databases including the threat assessment tool for comparative analytics, "contractor[s] should not be allowed to use student attributes to make predictions that have not been shown to have a causal relationship with gun violence" (p. 6). Similarly, the Florida ACLU (2020) is concerned about increased student surveillance associated with SB 7026, making the point that "we must be careful not villainize those struggling with mental health issues or create artificial barriers or consequences to access to mental health services" ("What does the 'Marjory Stoneman Douglas High School Public Safety Act' Mean for Students?"). Most notably, thirty-three advocacy groups (2019) signed an open letter to the current Florida Governor Ron DeSantis illustrating these concerns. As the groups warn, "without safeguards and protections, the state risks building a structure to systematically discriminate against students based on protected statuses." While news coverage of the MSDHSPSA often centers on what appear to be conflicting values about gun control, advocacy groups remain concerned about social justice, surveillance, the correlation of gun violence and MH, and the collection of sensitive data for the purpose of building comparative analytics designed to reduce violence.

Technical and professional communication has frequently examined discursive webs of policy born of tragedy much like this one (DeVasto et al., 2016; Schuster & Propen, 2015; Knievel, 2008). Policy documents, constructed as a response in the wake of tragedy, can reveal insights about public institutions (Reamer, 2015) and public expectations for government (Ding, 2013). Insights from these analyses lead to additional knowledge about a public's values (Grabill & Simmons, 1998) and the actions they deem appropriate in response to crisis (Frost, 2013). Though the MSDHSPSA's documents are not without controversy, they limn prevailing public beliefs about MH, mental illness, and the role of institutions and governments in intervening in the lives of individuals with MH concerns. Investigating the mandates of SB 7026 and related MH legislation from Chapter 394, then, gives me the opportunity to 1) examine prevalent beliefs about MH concerns promulgated by public policy and 2) identify moments when these beliefs become material as the legislation is enacted. In this chapter, I take on this first task by identifying six dominant narratives about MH present within SB 7026 and Chapter 394. Chapters 3, 4, and 5 take up this second task.

Dominant Narratives

Dominant narratives are beliefs so commonly held that they become implicit. Created by a dominant social group in order to grant itself authority and silence alternative voices, dominant narratives are retold through numerous texts. These narratives, as Lien et al. (2018) note, are presented as easily comprehensible origin stories that create order through binary divisions: "the civilized from the savage, the domestic from the wild, progress from regress" (pp. 1-2). Intersecting with race, class, gender, and ability, dominant narratives normalize white, capitalist, masculine, abled hegemony (Smirnova, 2018; Mapp, 2016; Jewkes et al., 2015; Bradley, 2013). The maintenance of these narratives is predicated upon the silencing of others. As Winters

(2016) writes, dominant narratives about race "encourage people to forget, deny, or downplay the violence that happens against people of color in the name of progress" (p. 13). Silencing results in the oppression and erasure of others, or those who have been othered. Holland (2012) asserts about race that "we are still made to choose a category, to state who our people are, and to relate to one cultural mode of being over and against another as if categories, communities, and belonging are positioned in finite relationship" (p. 5). While dominant narratives are presented as objective, apolitical ways that the world works, they capacitate harm against othered groups.

Studies of dominant narratives seek to name them, understand their normalization, and determine the harm they have done. For example, Thomas et al. (2020) examine how poverty narratives normalize those who live in "poor" neighborhoods as socially undesirable, lazy, or dysfunctional. Dixon (2018) interviews who the author terms mentally disordered offenders to understand how they use mental illness narratives to explain their behavior. As well, Parsons (2016) finds that parents and caregivers of Black children use narratives to purport "the ideology that overweight and obesity are necessarily associated with health status and that overweight and obesity occur due to an individual's choices" (p. 606). Other studies seek to redress the injustices caused by dominant narratives by presenting counternarrative responses from individuals who have been othered (Quiros et al, 2019; Olan & Richmond, 2017). These analyses of dominant narratives are useful because they explicate what dominant narratives are and examine the discourses that lead to their social usage.

TPC Scholarship and Dominant Narratives

Critiquing dominant narratives requires naming them and explaining how they might constitute harm. TPC scholars have engaged with dominant cultural narratives before; sometimes

called "dominant discourses" or "dominant themes." Commonly, these studies present examples from the research subject(s) to show resistance or conformity with a given narrative. Jones (2017), for example, examines how Black entrepreneurs use rhetorical agency to resist dominant narratives, while Verzosa Hurley and Kimme Hea (2014) call for resistance against dominant approaches to social media. Other TPC scholars find evidence of master or meta narratives in policy documents and institutional texts: Carnegie & Abell (2009) analyze library governance documents in search of metanarratives, while David (1999) finds master narratives of elitism within an art museum's press releases. Sheehan & Rode (1999) use the term "dominant theme" to describe narratives of the Enlightenment within scientific discourse. method is similar as they locate dominant narratives of Enlightenment within science. These studies contribute to TPC's focus on social justice work (Walton et al., 2019; Eble, 2020)[24].

When dominant narratives about MH are habituated into thought, action, and daily life, policies may emerge that can harm people with MH conditions. As Jones et al. (2016) find in their analysis, dominant narratives tend to be the stories that are repeated (p. 4). Due to their social habituation, dominant narratives are difficult to identify. Jones and Walton (2018) note that this difficult identification makes dominant narratives pervasive. However, as this section has shown, questioning dominant narratives can lead to insights about the ways they impact discourse and identity. These analyses can highlight the discursive effects of dominant narratives on social problems; in this chapter, the normalization of state control over individuals with MH

[24] As Jones et al. (2016) note, social justice work has only recently been recognized as a mainstream area of study in TPC. Seeking out dominant narratives about social justice, for example, would be insufficient because they would replicate TPC's existing narrative of the field as acultural and apolitical. Jones et al. (2016) propose *antenarratives* as a way of "[making] visible competing (i.e., a collection of nondominant) narratives about the work our field can and should do" (p. 2). I concur with Jones et al. that recognizing antenarratives (along with dominant narratives) enables the field to better grasp the capacity of language to perpetuate inequalities. However, antenarratives are beyond the scope of this dissertation.

concerns. For this project, the first step toward addressing dominant narratives about MH is to highlight them within two pieces of Florida MH legislation: SB 7026 and Chapter 394.

In the next section, I reiterate my research questions, the first of which is the focus of this chapter. After explaining and justifying the techniques I use to address my first research question, I identify six dominant narratives present in SB 7026 and Chapter 394: 1) individuals with MH concerns should be identified; 2) MH concerns should be identified by behavioral signs and symptoms; 3) MH education should help individuals identify MH concerns; 4) MH treatment should address MH concerns; 5) Individuals with MH concerns should access MH evaluation and treatment; and 6) The state should mediate MH evaluation and treatment. I phrase these dominant narratives using the conditional "should" to emphasize how policies based on this legislation force implementation of these narratives. I argue that understanding dominant narratives circulating in the MH legislation I study is essential because these narratives help normalize the state's identification of and control over individuals with MH concerns. This analysis expands in Chapter 4, as I examine the proliferation of dominant narratives as they are enacted within school districts. SB 7027 and Chapter 394 require school districts to enforce policies and practices that mark students with MH concerns in harmful ways. For example, SB 7026 draws on the dominant narrative that the state should mediate MH evaluation and treatment to authorize the creation of a threat-assessment tool that collects information about students' MH concern and shares that information with school district personnel and law enforcement. This practice may be harmful due to its potential to label students as threats based on their MH status. Ultimately, tracing dominant narratives through legislation (Chapter 3) into mandates that mark individuals with MH concerns for further evaluation and treatment (Chapter 4) helps me link those narratives to stigma (Chapter 5).

Research Questions

This dissertation focuses on three primary research questions:

1. How has MH legislation in Florida addressed the risk of dangerous behavior from individuals with MH concerns? How has the perception of "dangerous" behavior resulted in increased institutionalization of individuals with MH concerns?
2. How does MH legislation in Florida include dominant narratives about people with MH concerns?
3. To what extent are dominant narratives about MH present in school districts' MH plans? How do dominant narratives influence the creation of comparative analytics that label students with MH concerns as potential threats?
4. How can school district's MH plans avoid the implication that students with MH concerns are potential threats? How can school district's MH plans break the misconnection between academic achievement, MH, and the potential for violence?

The second of these research questions is addressed here as I conduct both close readings of SB 7026 and Chapter 394. I explore how these pieces of MH legislation draw upon dominant narratives about individuals with MH concerns to normalize the state's identification of and control over these individuals.

Close Reading

To analyze Chapter 394 and SB 7026, I conduct close reading to seek out dominant narratives about MH. Close reading critically analyzes the meaning behind a text's use of patterns. Moya (2016) traces critical reading's history from its beginnings in New Criticism to its status today, as critique of multimodal texts, ecocriticism, datamining and quantitative analysis, as well as the author's own sociocultural approach to literary study. Moya (2016) takes up

several questions about close reading, among them: “What is the power of a work of literature to affect a reader's perception of his or her world? How might a nuanced and insightful interpretation of a given text affect our perception of that text--and by extension, of the worlds it represents?” (5). As Moya (2016) contends, these questions help us comprehend social categories' impact on experiences and identities. Using assemblage theories from Latour and Bourdieu to imagine literature as a complex system of multiple actors, Moya (2016) positions the text as the entry point to this system; close reading becomes a way of understanding a society's "pervasive sociocultural ideas" (p. 8). Constructed like this, close reading becomes a means of understanding ideology within texts.

Close reading has been used previously to understand dominant narratives within texts. In a study of political views and food references, Ross & Mapes (2020) used close reading and coding to identify dominant narratives about the foods purportedly eaten by Republicans and Democrats. Ferguson (2019) uses close reading to demonstrate the dominant climate security narrative of resilience. Meanwhile, Bishop (2017) closely reads digital media produced by undocumented immigrants to find DREAMer narratives that highlight individuals who are high-achieving and highly educated (p. 424). Close reading works to understand dominant narratives because the ideologies that produce dominant narratives are systematic; patterns of words tend to be associated with the ideology of that dominant narrative. As Brummett (2019) writes, "identification of ideology through close reading gives us a window into the larger scheme of beliefs and values held by people--and thus, into what their sense of social justice might be" (n.p.). Understanding legislation and policy documents as emblematic of a public’s values, close reading of these texts can yield insights about social (in)justices in which that public participates.

In this chapter, I closely read SB 7026 and Chapter 394 to identify dominant narratives of MH, organizing my analysis around the normalization of MH identification and treatment. I choose these dominant narratives because they represent common concerns for those who study MH and disability (c.f. Hanganu-Bresch & Berkenkotter, 2019; Yergeau, 2018; Price, 2011). Moreover, I analyze the legislation's positioning of the state as the agent that mediates identification, access to treatment, and continued surveillance of identified individuals. I interpret this state-mediated action as institutionalization. In developing this view on institutionalization, I am reminded of Foucault (1975, republished 2008), who described government surveillance and control within a plague-ridden town. As a tool of government, surveillance becomes a constant means of inspection, of determining who is "mad/sane, dangerous/harmless, and abnormal/normal" (p. 4). I use this broad view of institutionalization to find out how Chapter 394 and SB 7026 present these actions as a normal response to individuals with MH concerns, reinforcing the connection that these individuals' existence is counter to public health, as in Chapter 394, or public safety, as in SB 7026. In answering research question 2 through close reading, I name dominant narratives that normalize the discursive identification of individuals with MH concerns by the state.

Dominant Narratives about MH

In this next section, I analyze examples from Chapter 394 and SB 7026 to find dominant narratives that build on each other. I find six dominant narratives about MH: that individuals with MH concerns should be identified, that MH concerns should be identified by behavioral signs and symptoms, that MH education should help individuals identify MH concerns, that MH treatment should address MH concerns, that individuals with MH concerns should access MH evaluation and treatment, and that the state should mediate MH evaluation and treatment. To

help with close reading, I use theories about MH and disability to point to problematic elements within the text. I also highlight contradictions within the text to show how dominant narratives undermine themselves. While attempting to navigate these contradictions between mental illness and public safety, Chapter 394 ends up proposing an idea that makes no sense. I highlight these examples to show that promulgating dominant narratives does a disservice to all stakeholders, not just individuals with MH concerns.

Individuals with MH Concerns Should Be Identified

Chapter 394 foremost directs Florida's Department of Children and Families to build a comprehensive MH program for the state. The program's implementation depends on identifying people who require treatment to access MH services. These people include "priority populations" identified by the legislature (394.674). Priority populations consist of "Adults who have severe and persistent mental illness," "Persons who are experiencing an acute mental or emotional crisis," Children who are at-risk for or have an "emotional disturbance," and "Children diagnosed as having a co-occurring substance abuse and emotional disturbance or serious emotional disturbance" (394.674). The dominant narrative is that individuals should be identified based on their MH concerns for access to state-provided MH services.

Given the purpose of Chapter 394, an act designed to "reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders," identifying those who are perceived to have these disorders seems to be a reasonable purpose (394.453). Yet to identify people on basis of their perceived MH concerns is to mark them as other. This identification constitutes an aporia, or an irresolvable internal contradiction. Resolution to the issue of identification comes only if MH stigma is erased; since MH legislation reinforces stigma, the contradiction continues. The legislature intends that the priority populations

identified in this act should be reduced, indicating state-supported population control. In SB 7026, the population becomes a "target" that should be identified based on their "psychiatric problems" (line 516, line 532). Whereas Chapter 394 identifies individuals on basis of MH concern for the purpose of public health, SB 7026 identifies these individuals for the purpose of public safety. Thus, when SB 7026 authorizes school districts to "identify and understand the signs of emotional disturbance, mental illness, and substance use disorders and...help a person who is developing or experiencing an emotional disturbance, mental health, or substance use problem," the piece of legislation indicates that identification of these individuals will assist public safety (lines 2407-2410). Individuals with MH concerns are generally not considered to be dangerous, violent, or threats to public safety, yet the dominant narrative authorizes their identification to make schools safer.

Identifying individuals on basis of MH concerns contributes to binary categories of ability and disability. These categories[25] reinforce the dominant status of ability, while disability is rendered invisible (Dolmage, 2017). As Price (2011) notes, referring to institutional perspectives on MH, mental disability is construed as an aberration, one that should be "stifled or expunged as quickly as possible" (p. 231). These binaries of ability and disability are spurious, argues Puar (2017), showing how disability is abstracted from the sociotechnical forces that have contributed to that disability. This sociotechnical binary between ability and disability results in what Lauren Berlant (2007) describes as "slow death," where "deterioration of people in that population … is very nearly a defining condition of their experience and historical existence" (p. 754). By slow death, Berlant and Puar are describing the consequences of systemic

[25] Berthoff's (1990) killer dichotomies refer to the ways that texts and readers work together to make meaning. In my project, MH legislation demonstrates control over the reader (citizen), and deputizes the reader to enact further identification of individuals with MH concerns.

categorization on a population, with consequences that impede what Puar calls "the maintenance of living on" (p. 12). Categorizing individuals based on perceived MH concerns can identify them for "premature or slow death" (p. 13). From a biopolitical perspective, identifying individuals on basis of MH condition creates categories that mark[26] individuals for life or death.

MH Concerns Should Be Identified by Behavioral Signs and Symptoms

Both Chapter 394 and SB 7026 present behavioral signs and symptoms as the way to identify individuals with MH concerns. Linking behavioral signs and symptoms to MH suggests that MH concerns consist of behaviors that observers find nonnormative. Under Chapter 394, these behaviors "interfere with or limit his or her role or ability to function in the family, school, or community" (394.492). The use of the word "function" describes the severity of the behavior, which for individuals identified under Chapter 394, presents a "problem" or "difficulties" that should be addressed (394.496, 394.658). If not addressed through treatment, the legislature finds what they term behavioral health disorders to be "major health problems for residents of this state, are a major economic burden to the citizens of this state, and substantially increase demands on the state's juvenile and adult criminal justice systems, the child welfare system, and health care systems" (394.9082). The connection between behavior and MH comes later in Chapter 394 when the act clarifies that behavioral health services refers to MH and substance abuse prevention and treatment services (394.9082). Based on this definition, the legislature authorizes that behavioral health and MH can be used interchangeably, suggesting that MH is determined by the behavior of individuals.

SB 7026 replicates this connection between behavior and MH by requiring collaboration between school districts and the community multiagency network to address behavioral health in

[26] Puar (2017) uses the phrase "folded into life," a term based on her use of assemblage theory (p. 4).

students. Multiagency networks include social services and law enforcement. SB 7026 notes that students can be identified based on their behavior and social function (line 536). Serious behavioral conditions include "Repeated failures at less intensive levels of care; Two or more behavioral health hospitalizations; Involvement with the Department of Juvenile Justice; A history of multiple episodes involving law enforcement; A record of poor academic performance or suspensions" (lines 584-589). Linking academic achievement and disciplinary concerns with MH implies that these behaviors can all indicate an MH concern and may necessitate MH treatment. Training addresses the recognition of these behaviors by understanding the "signs of emotional disturbance, mental illness, and substance use disorders" (lines 2409-2410). For Chapter 394, these signs become medical symptoms denoting the presentation of: "serious emotional disturbance" (394.494), "acute mental illness" (394.66), "severe distress or mental illness" (394.67), "disabilities associated with mental illness" (394.67), or "mental health problems" (394.875). Connecting behavioral with MH concerns can impact the purpose and type of treatment provided to address these concerns.

Addressing behavioral concerns under MH legislation emphasizes helping individuals with these concerns to behave differently. Interventions then enable students to "learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living" (lines 1727-1728). Behaviors are categorized as appropriate and inappropriate value dualisms; students are expected to present appropriate behaviors. Referral for MH services under these categories is a disciplinary measure intended to achieve this outcome, though SB 7026 makes allowance for other disciplinary measures as well, including referral to law enforcement. When interventions are constructed as opportunities for students to "learn appropriate behaviors," then behaviors are perceived as actions that students are expected to

control. Equating behavioral health and MH may lead to the perception that students are expected to control MH as well, evinced by their behaviors.

MH Education Should Help Individuals Identify MH Concerns

Education is considered an integral for addressing both MH and substance abuse concerns. Both Chapter 394 and SB 7026 include provisions for this education, indicating that MH education is a necessary component of MH treatment. Education[27] appears in Chapter 394's sections of legislative intent, recovery support, treatment quality, service planning, prevention, and ancillary services. The distribution of MH education throughout all portions of the MH recognition and treatment process shows the prevalence of the dominant narrative. What is missing from discussion about MH education, however, is what that education entails. No description of education program outcomes or objectives exists in Chapter 394. SB 7026 provides more detail on requirements for its required youth MH awareness and training program, created by the Florida Department of Education to "help school personnel identify and understand the signs of emotional disturbance, mental illness, and substance use disorders and provide such personnel with the skills to help a person who is developing or experiencing an emotional disturbance, mental health, or substance use problem" (lines 2408-2413). These outcomes indicate that education's purpose within state supported MH services is to identify individuals with MH concerns.

The Florida Legislature's requirements for the development of youth MH awareness and training center on ways to identify students who may be experiencing MH concerns. Such training begins by overviewing mental illness and "the need to reduce the stigma[28]" (line 2428),

[27] Chapter 394 also includes requirements for the education of MH professionals, but these results were not included in my analysis because they are not about MH education.
[28] Stigma is not mentioned again in SB 7026.

followed by risk factors and warning signs, information on engaging students who demonstrate these risk factors and warning signs, and advice on how to "identify and encourage the student to use appropriate professional help and other support strategies" (lines 2436-2437). While SB 7026 requires this MH education for school personnel, the Department of Education expanded this requirement to students within school districts as well in July 2019. Students are required to receive five hours of MH instruction per year, also focusing on the signs of youth mental illness. Education, as constructed in SB 7026, teaches that mental illness can be identified by signs, usually behaviors. These behaviors can be reported to available mental health services within the district, evoking the narrative that individuals with MH concerns should access MH evaluation and treatment.

The youth MH awareness training required by SB 7026 is administered through resources developed at both national and state levels. In keeping with SB 7026's requirement to "select a national authority on youth mental health awareness and assistance" (lines 2414-2415), the Department of Education uses Mental Health First Aid to provide instruction (MSD Public Safety Commission, n.d.). Adhering to the common theme, this resource "teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders" (National Council for Behavioral Health, 2020, n.p.). At state-level, the Florida DOE combines mental health first aid training with Hope for Healing, a multiagency resource launched by the current Florida First Lady Casey DeSantis (FDOE Press Office, 2019). The announcement of these resources draws on DeSantis's quote that "We know that 50 percent of all mental illness cases begin by age 14," (qtd in FDOE Press Office, 2019) a statement supported by the World Health Organization ("Child and adolescent health" 2020). In addition, at state-level, mandatory MH education in grades 6 through 12 focuses on signs of MH concerns, the process for getting

help from available resources, and interpersonal strategies for discussing MH concerns with peers. Replicating dominant narratives about MH concerns being a problem to be addressed through MH treatment, MH educational initiatives focus on recognizing signs of MH concerns as a preliminary step to treatment access.

One year after its launch, Hope for Healing Florida remains a work-in-progress for coordinating communication among "private sector partners to produce and distribute mental health and substance abuse resource materials throughout the state" (FDOE Press Office, 2019). As of summer 2020, users who visit the site are given two options via the banner at the top of screen: "I Need Help Now" or "Other Ways To Get Help." That these options are the first users interact with indicates that those seeking information about MH need help of some variety. Users are given seven options for help resources about: suicide, locating treatment options, depression and anxiety, abuse, bullying[29], disaster coping, and a threat-reporting app, FortifyFL. Of these help resources, six were developed by public agencies and two by nonprofit organizations, counter to the claim that the website works with private sector partners. Though the website provides users with access to resources for addressing these problems, the text reassures users that "Getting help isn't just for people who have problems" before reassuring that "It doesn't matter what anyone thinks about it" ("What will my friends think," 2019). The first sentence implies that the user is perfectly justified in seeking help, while the second sentence implies that help-seeking behavior will be judged by the user's friends. The second sentence lessens the stigma-mitigating appeals of the first. In any case, the website's claims evoke the dominant

[29] The website encourages users to report bullying, informing them that "you aren't a tattle-tail" [sic] ("I Need Help Now," 2019). The website does not include the information that students who report being bullied are subject to MH and threat assessment under SB 7026 (Schaffhauser, 2019).

narrative of MH education; that education exists to connect individuals with MH concerns to MH treatment.

Constructed in this way, the dominant narrative of MH education is that it exists to identify individuals with MH concerns. Program outcomes consistently focus on recognizing the signs of mental illness, in keeping with the narrative that mental illness requires medical treatment to be alleviated. Moreover, MH education focuses on referring individuals with MH concerns to state agencies for evaluation and treatment[30]. Coverage of identification methods and the MH treatment process further normalizes the dominant narratives at work within MH legislation: individuals can be identified based on their signs, symptoms, and other behavioral indicators. These manifestations mark[31] the individual for MH treatment and subsequent surveillance by the state.

MH Concerns Should Be Addressed by MH Treatment

In both SB 7026 and Chapter 394, MH concerns are presented as problems to be solved through MH treatment. Individuals with MH concerns are referred for MH treatment in order to attain "achievement" or "recovery." Describing MH concerns in this way positions them as a deviation from normative MH. When MH treatment is presented as the means by which individuals with MH concerns are expected to, as SB 7026 mandates, "learn appropriate behaviors," the legislation is invoking the language of cure (line 1727). Theorized by Clare (2017), the ideology of cure requires individuals with MH concerns to be damaged, different from an idealized original nondisabled state. MH treatment, using the language of cure, is positioned to allow

[30] MH education does *not* mention that such a referral will be reported at the district level, that the district is authorized to share such information with law enforcement, and that such referrals must be reported upon subsequent school registrations until the student graduates.

[31] From the Greek, *stigma* is a mark inflicted on an individual to denote their condition. Texts construct stigma by dictating the physical practices the state uses to mark individuals with MH concerns.

individuals to return to that state. Both pieces of legislation use the term "recovery[32]" to describe this action; Chapter 394 adds the term "rehabilitation" to the discourse (394.9082). MH legislation constitutes MH concerns as a disability that treatment should address.

Positioning MH treatment as the means by which MH concerns should be alleviated medicalizes mental illness. While mental illness is a complex condition with multiple factors, MH legislation assumes one response; MH evaluation and treatment of the individual. Chapter 394 even: "[Recognizes] that mental illness and substance abuse impairment are diseases that are responsive to medical and psychological interventions and management that integrate treatment, rehabilitative, and support services to achieve recovery" (394.66). Though the legislation may be responding to the moral model of mental illness and substance abuse, which conceived the conditions as moral failings occurring in defective people (see Frank & Nagel, 2017, for discussion on the moral model and brain disease model), medicalizing mental illness reinforces the dominant narrative that MH concerns are indeed a defect[33] in need of medical treatment. Mental illness becomes a biological concern, fixable through medical evaluation and treatment.

Yet despite this language of cure throughout Chapter 394 and SB 7026, both acts contradict their conception of the medical, biological "brain disease" model of mental illness. The acts do this by implying that MH treatment should enable individuals to become responsible[34] for their MH conditions. The idea that individuals can assume responsibility for a

[32] "Recovery" is commonly used in substance abuse discourse, particularly in relation to cognitive-behavioral therapy, to similar effect (Laudet, 2008). The term implies that it should be possible for a person to recover from their substance abuse. While both pieces of MH legislation apply to substance abuse as well, I chose examples from the text that pertained to MH.

[33] Both pieces of legislation use the term "defective" to comply with federal law restricting firearms access to individuals who have been adjudicated as mentally defective. Chapter 394 further uses the term "defect" to refer to a "small but extremely dangerous number of sexually violent predators exist who do not have a mental disease or defect that renders them appropriate for involuntary treatment under the Baker Act" (394.910).

[34] Language about responsibility is commonly used in cognitive-behavioral therapy, a dominant mode of MH treatment and one that I have critiqued (see Walkup and Cannon, 2018).

brain disease is a contradiction and indicates conflict between the dominant brain disease model and the older moral model of MH treatment[35]. In Chapter 394, treatment should "encourage" individuals with MH concerns to "assume responsibility for their treatment and recovery" (394.453); SB 7026 "[promotes] responsibility among students" for helping to identify potential threats to school safety (line 1852). Under this contradiction, MH treatment becomes less a cure than an incentive. Youth MH training programs, for example, "encourage the student to use appropriate professional help and other support strategies" (SB 7026, lines 2436-2437). The dominant narrative presents MH treatment as the cure for MH concerns, but individuals have a responsibility to seek out MH treatment. This is "responsibilization," a term sometimes used to describe the shift of responsibility onto those accessing MH treatment in critiques of the neoliberal healthcare model (Brown, 2019; Whittle et al., 2019). The onus for cure is then placed on the individual; failure to improve becomes evidence of the individual's noncompliance instead of necessitating alternative MH treatment, as might be expected if the legislature adhered to the medical model of MH treatment.

Legislatures have good reason to support this contradiction; constructing medical intervention as an adjunct to an individual's responsibility for improvement allows medical treatment to become finite. While mental illnesses often recur, and those with mental illnesses often require ongoing support, positioning MH treatment as a fixed resource allows the legislature to end services. This positivist narrative of MH, which, as Price (2011) comments, "focuses on causes, chemicals, and cures," presents recovery as the assumed end goal for individuals with MH concerns (p. 52). When the individual is able to "return to the community"

[35] The brain disease model (most commonly researched in connection to addiction) has been disputed due to its emphasis on neuroimaging, but I prefer it to the moral model promoted by presenting mental illness as the responsibility of the individual.

and “live successfully,” MH treatment ceases (394.453). Presenting MH treatment as a temporary stop on the road to recovery is a perspective that allows for the “economical use” of resources (394.75). This view of MH treatment carries over to private-sector providers as well; as Price (2011) notes about the "tendency of American medical systems to intervene in 'problems' rather than practice a more holistic form of care" (p. 12). Yet when medical treatment does not end in cure, individuals’ “problems” are subject to the language of responsibility distributed throughout the MH legislation.

The dominant narrative that MH treatment should address MH concerns assumes that treatment exists to help individuals take responsibility for their own MH concerns. Contrary to the “disease” of mental illness that the legislature in Chapter 394 recognizes, relegating medical intervention to an adjunct of an individual’s responsibility for their MH condition may result in an individual’s perceived noncompliance. As a consequence, Chapter 394 authorizes an individual with a “history of lack of compliance with treatment for mental illness” to be involuntarily treated under certain conditions (394.4655). Placing responsibility on individuals for their lack of achievement or improvement given access to (finite) MH treatment produces what Puar (2017) terms “crip nationalism”, or the capacity of individuals to participate in empowerment discourses (p. 70). Under these discourses, disability is perceived to be a “singular misfortune and a private tragedy” (p. 70). Those whose conditions have improved via treatment are “lauded,” as evidence of empowerment’s efficacy (p. 72). For those who are perceived to lack compliance, however, the dominant narrative does not consider the socially constructed determinants of disability. Positioning MH treatment as a cure for MH concerns allows those concerns to remain the province of the individual rather than a biopolitical instrument that silences those who do not conform to the dominant narrative.

Individuals with MH Concerns Should Access MH Evaluation and Treatment

Medical contact is a presumption under both pieces of legislation. SB 7026 amends Chapter 394 to include MH screening and assessment under the services provided to children and adolescents. No provision is made for those who may wish to opt out of MH screening; medical contact is a foregone conclusion. This dominant narrative imbricates individuals with MH concerns within medicalized discourse. People become patients due to this narrative. In Chapter 394, a person becomes a patient when they are "held or accepted for mental health treatment" (394.455). Until that point, the individual is still a person in need of "screening and evaluation for mental health or substance abuse disorders" (394.455). The laws presume that their adherents are all in need of MH evaluation and treatment, though I temper this speculation by noting that this presumption may be in keeping with the laws' purposes. Medical contact, mediated by the state, becomes part of the dominant narrative about MH concerns.

Under this narrative, MH concerns are a problem necessitating medical treatment, resulting in recovery. Those who decline medical evaluation or treatment under this narrative may be perceived as noncompliant, a designation that may potentiate medical evaluation or treatment regardless of the individual's preferences. This consequence is due to Chapter 394's determination of competency and consent. Under Chapter 394, individuals who can voluntarily consent to MH treatment are deemed competent after understanding information about the proposed MH care plan. Consent and competency are then linked under the act; to be competent is to consent to MH treatment. Chapter 394 defines "incompetent to consent to treatment" as a "state in which a person's judgment is so affected by a mental illness or a substance abuse impairment that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical, mental health, or substance abuse treatment" (394.455).

A person who is incompetent to consent to treatment is then assigned a guardian who can consent. The slippage between competency and consent yields the assumption that treatment is the default outcome of MH concerns—an outcome aligned with the presentation of MH concerns as a problem to be solved.

The dominant narrative allows these designations of competency based on an individual's consent to receive treatment due to the identities created under MH legislation. While both Chapter 394 and SB 7026 use person-first language[36], legislation creates numerous identities based on a person's perceived capacity to access treatment. Chapter 394 in particular defines sixteen different identities for those it legislates. These identity designations are mediated based on determinations (in some cases, court adjudication) of MH status. For students under SB 7026 and Chapter 394, five designations apply. A child or adolescent may be "[a student] with emotional and behavioral disabilities" (SB 7026, line 178), "at risk of emotional disturbance" (394.492), "who has an emotional disturbance" (394.492), "who has a serious emotional disturbance or mental illness" (394.492), or "who is experiencing an acute mental or emotional crisis" (394.492). These identities are determined based on contact with MH treatment and cemented by the action of diagnosis. Interestingly, for children and adolescents, mere diagnosis with a mental illness results in a designation of emotional disturbance, considered a mental illness under law only when the child "exhibits behaviors that substantially interfere with or limit his or her role or ability to function in the family, school, or community" (394.492). The conflict between medical and legal identities here is indicative of the greater identity work that individuals brought into contact with state-mediated MH evaluation and treatment must perform.

[36] Part V of Chapter 394 does not use person-first language to address the "small but extremely dangerous number of sexually violent predators … who do not have a mental disease or defect that renders them appropriate for involuntary treatment under the Baker Act" (394.910). These individuals are involuntarily committed based on "the risk these sexually violent predators pose to society" (394.910).

Yet individuals under Chapter 394 and SB 7026 must perform patienthood due to the acts' adherence upon MH treatment as a necessity to improve one's MH status. The nonpatient options are limiting; these individuals may be judged incapacitated or incompetent and may be appointed a guardian who can give consent to receive treatment. Individuals identified under these MH acts may not be able to retain autonomy without taking on the identity of patient, a decision at odds with autonomy itself, as well as the seemingly voluntary notion of consent. Individuals with MH concerns subject to MH legislation also become subject to the dominant narrative that MH services can "help to eliminate, reduce, or manage symptoms or distress" arising from their mental status, as well as "[reducing] the risk for or [delaying] the onset of mental disorders" (394.67). This presumption reinforces the idea that MH concerns are a disability to be mitigated through treatment and its conference of patienthood.

Individuals with MH concerns should *be able to* access MH evaluation and treatment. Under the current dominant narrative, however, access is positioned as a foregone conclusion. Enacted through MH legislation, access is mediated by the state. Docile bodies, to borrow Foucault's (qtd in Rabinow, 1984) term, "may be subjected, used, transformed, and improved" (p. 180). These methods constitute discipline, which tends to silence those who do not conform to the dominant narrative. Silencing may constitute those who refuse treatment and are designated incompetent but may also apply to individuals with MH concerns who do not want to access treatment due to the pervasive narratives forwarded by these discourses. For those who may not view MH concerns as problems to be cured through treatment, the way to avoid these discourses is not to be identified under the legislation; the performance of normalcy to avoid the performance of patienthood.

The State Should Mediate MH Evaluation and Treatment

By enacting MH legislation, the state takes on responsibility for ensuring that individuals with MH concerns are evaluated and treated. This intervention expands as the state (or its deputies) take on the responsibility for the identification, evaluation, surveillance, and assessment of individuals with MH concerns. This dominant narrative aligns with well-founded biopolitical critiques of the carceral state (Puar 2017; Benjamin 2019). Control over individuals with MH concerns begins at the identification of nonnormative behaviors. Under Chapter 394, this behavior must be recent and threaten the well-being of the individual or others (394.467). Under SB 7026, behavior that is perceived as "unsafe, potential harmful, dangerous, violent, or criminal" may cause the individual to be identified. Individuals are identified by groups designated by the state: "state hospitals and other hospitals; city, county, and state health and family service agencies; drug abuse and alcoholism programs; probation departments; physicians; psychologists; social workers; marriage and family therapists; mental health counselors; clinical social workers; public health nurses; school systems; and all other public and private agencies and personnel" (394.75). Deputized to identify individuals with MH concerns, the state remains in control over MH evaluation and treatment and thus in control over the individuals who access these services.

This need for identification of individuals with MH concerns carries over to school-age children and adolescents as well. In response to the shooting at MSDHS, the legislature commissions a report on "all perpetrator contacts" with state agencies[37]. These agents, including schools, law enforcement, courts, and social services must produce the "history of interactions" with the perpetrator, implying the existence of such interactions. The legislature's aim is to

[37] SB 7026 elaborates: "local, state and national government agencies and entities and any contract providers of such agencies and entities" (lines 1525-1527). My usage of "state" includes the government and its deputies.

identify "failures" by these agents to "communicate or coordinate regarding indicators of risk or possible threats," thus rendering the state responsible for the resulting deaths and injuries (lines 1550-1556). The state's willingness to take on the responsibility for the failures of its agents is indicative of its involvement in the control of individuals with MH concerns for the purpose of public safety. Interestingly, the report commissioned under SB 7026 recognizes multiple failures by objects including an "open and unstaffed gate," an "unlocked and unstaffed door," and six instances of radio failures ("Marjory Stoneman Douglas High School Public Safety Commission Initial Report" p. 42) as well as so-called "command and control" failures by law enforcement personnel at the time of incident, but only names two state agents for failures to identify previous interactions with the shooter: the FBI (p. 265) and the school's principal (p. 286). The report instead notes that the shooter was the ultimate cause of the incident, rebutting the state's purported responsibility for identifying individuals with MH concerns[38] as potential threats to public safety.

The legislature's insistence that individuals with MH concerns be identified, evaluated, and assessed creates a repository of data on these individuals. SB 7026 authorizes the creation of crime watch programs that intake the anonymous reports of potential threats to school safety. School districts, moreover, are required to be aware of students who are referred to MH services under SB 7026. Students are brought into compliance with this network upon registration in subsequent school districts; they are required to report prior referrals for MH services (SB 7026, lines 182-183). Once identified, the act enables the Threat Assessment Team to determine the processes for threat-assessing these students. In this, the Threat Assessment Team is aided by

[38] In discussing the shooter's interactions with the state's MH apparatus, the report finds no failures in identification or threat assessment that would have prevented the incident (p. 271).

access to students' criminal histories and by results from the risk assessment tool[39] (SB 7026, line 1977). By requiring coordination between state agents regarding interactions with students who have MH concerns, the state is building an apparatus that collects information on this vulnerable population. Chapter 394 then authorizes this information to "be used for statistical and research purposes," though the legislature recognizes that this availability should be limited by the need for privacy (394.4615). The state becomes the arbiter of MH evaluation and treatment because it has, or directs its agents to have, all the data.

When the state controls referrals for MH services, those referrals are conflated with medical diagnosis itself. This conflation seems objective due to the presence of medical providers within the network. Yet the medical providers do not have the power to remove the designation of individual with MH concerns (i.e., a student's name is on the list because they are referred for MH services, not contingent upon medical diagnosis). The dominant narrative harms medical providers as well by limiting their power to intervene against the marking of individuals in opposition to public health and safety. This state-sponsored marking of individuals constitutes what Mbembe (2011) describes as the "matrix of the nomos," (p. 3-4). In this matrix, colonial machines diminish capacity of marked populations, reducing their ability to be perceived as agents. The constriction of agency results in the disability of mental illness, ironically a condition Chapter 394 attempts to mitigate.

By collecting data on individuals with MH concerns, as well as its implication that acts of violence occurred due to lack of communication between state agencies, MH legislation contains the dominant narrative that the state should mediate MH evaluation and treatment in order to serve the goals of public and school safety. Yet because most individuals with MH concerns are

[39] The Florida Safe Schools Assessment Tool has apparently changed since its conception in SB 7026; SB 7030, enacted one year later, clarifies that this tool assesses the physical safety of a site (p. 22).

not violent (National Alliance for Mental Illness, 2019), collecting data on these individuals is not likely to result in a safer public. State identification and evaluation of individuals with MH concerns may then be what STS scholar Ruha Benjamin deems racist and classist social control. As Benjamin (2019) writes about technocorrections, "these interventions come bubble wrapped in rhetoric about correcting, not just individuals, but social disorders such as poverty and crime" (p. 1-2). Indeed, Chapter 394 makes the claim that in children and adolescents, MH treatment may prevent "substance abuse, unintended pregnancy, delinquency, sexually transmitted diseases, and other negative consequences" (p. 51). This myth of correction leads to what Benjamin (2019) terms "a sticky web of carcerality," exemplifying the consequences of this dominant narrative.

Conclusion

Close reading of Chapter 394 and SB 7026 using scholarship in disability biopolitics leads me to conclude that this MH legislation positions the state as a mediating apparatus designed to identify, survey, and act upon individuals with MH concerns. Given that the legislature wrote these documents, this conclusion is perhaps expected. As these six interlocking dominant narratives purport, individuals with MH concerns deviate from public health and public safety and so surveillance of these individuals is justified given their deviant status. Chapter 394 and SB 7026 normalize the construction of individuals with MH concerns as deviant. Policy documents based on the legislation license to act further on these individuals. Given the concern that policies mandated under MH legislation will actually stigmatize individuals with MH concerns, examining the dominant narratives here helps show that such stigma is created within the legislation itself.

In this chapter, I addressed my second research question through a close reading of SB 7026 and Chapter 394. In the next chapter, I build on this close reading by finding evidence of these dominant narratives within school districts' MH plans. I use those results to show the ways that dominant narratives result in material actions against students. My analysis focuses on policy documents that mandate that students be reported to the state on basis of MH condition. I use the concepts developed in this chapter to identify these narratives and explain the connections between legislation and policy. I then use computational text analysis to support my findings through authorship attribution techniques, a method I use to assert that legislation normalizes state control over individuals with MH concerns. Computational text analysis also addresses a project limitation; that the 2018 MH plans were developed hastily in response to new legislation and that the 2019 MH plans may differ. I compare texts to show that many school districts' 2019 MH plans are very similar to their 2018 counterparts. The next chapter draws on this chapter to find both qualitative and quantitative connections between state legislation and school districts' MH plans.

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Chapter Four: Mental Health, Comparative Analytics, and State Surveillance

"The Threat Assessment Team (TAT) will review pertinent data to assess, diagnose, and develop an action plan for the student, as outlined below. If the interventions are not successful and/or require outside agency involvement, the TAT will refer the student to the MAN, and share information regarding the student"

—*Sumter County Mental Health Plan*, p. 1. MAN refers to a state-run multiagency network of school personnel, social services, and law enforcement.

In this chapter, I conduct stylometric text analysis on MH plans to indicate the presence of dominant narratives. I use the results of this analysis to identify MH plans that contain more language related to dominant narratives and also to support my critique of SB 7026's mandate to develop a data repository on students who have been identified on basis of their MH concerns. To do this analysis, I overview the role of MH plans in carrying out the mandates of SB 7026, emphasizing in particular critiques about the MH plans' potential to label students with MH concerns or as potential threats. Then I perform stylometric text analysis via cosine similarity on 71 MH plans from 2018 to determine the prevalence of dominant narratives within their text. I continue stylometric text analysis via n-gram and bi-gram frequencies on sampled corpora to illustrate the efficacy of the original cosine similarity tests. I draw these two analyses together to illustrate the contingency of comparative analytics in determining results, noting that while computers can differentiate variability between data points, humans are ultimately responsible for determining what level of variability is acceptable, and thus for perpetuating the dominant narratives of MH. The next chapter concludes my analysis of dominant narratives within mental

illness diagnosis and the construction of stigma by identifying new directions for research on MH education and risk communication.

Legislative Background

Under SB 7026, Florida school districts are required to submit yearly MH plans to the Department of Education's Office of Safe Schools. MH plans generally include information on how the district plans to implement MH services, MH expenditures, program outcomes, and dates of district approval and plan submission. These plans generally take 3-25 pages to detail and are revised each year according to state guidelines for MH allocation funding. Importantly for this project, MH plans also contain information on how the district plans to gather student data for the "early identification of social, emotional or behavioral problems or substance abuse disorders" as well as information on the district's threat assessment team and subsequent threat assessment practices ("Mental Health Assistance Allocation Plan Checklist," 2020). These threat assessment practices are not included in the DOE's OSS MH plan checklist for schools, so their inclusion within MH plans is an intersection I seek to explore.

MH plans contain threat assessment practices at district levels, as required under SB 7026. There are two threat assessment aims within district MH plans: physical, or site assessment, and individual student assessment. Since SB 7026 allocates 98.9 million dollars for school districts to improve their building security, school districts are required to submit site assessments and if necessary apply for grants to improve the physical safety of campuses ("SB 7026 Impact on Schools," n.d.). This allocation also allows school districts to hire school resource officers (SROs). MH plans also include individual threat assessment of students, which is to be reported to the DOE. One of the mandates of SB 7026 is to create a "centralized and integrated data repository," which the DOE interprets to include data from school districts in

conjunction with the Department of Juvenile Justice (DJJ), the Department of Children and Families (DCF), the Department of Law Enforcement (DLE), social media data, and LE data[40] ("SB 7026 Impact on Schools," n.d.). In order for these agencies to share confidential information about the students with the school district's Threat Assessment Team (TAT), SB 7026 further waives information sharing restrictions. This data repository costs the state 3 million dollars annually. While the DOE is able to provide justification for the physical site safety threat assessment initiative via the MSDHS commission's findings about site security failures in the 2018 shooting ("Marjory Stoneman Douglas High School Public Safety Commission Initial Report,"2019), I could find no similar justification for the creation of this data repository.

While school districts have the option to develop addition threat assessment practices for their students, the DOE requires threat assessment plans to provide "early identification, evaluation, early intervention, and student support" (Florida Senate, 2019) To assist with this practice, the DOE uses the Comprehensive School Threat Assessment Guidelines, developed by a team of researchers from the University of Virginia ("Behavioral Threat Assessment," 2020). In particular, these guidelines include a threat report, mental health assessment, parent/guardian interview form, teacher/staff interview form, and a behavior intervention plan[41]. The purpose of this documentation is differently worded; the DOE advice states that "If there is doubt, the communication or behavior should be treated as a threat and a threat assessment should be conducted" (Office of Safe Schools, 2020) while the guidelines themselves read "If a student later carries out a threat that was previously judged to be transient, you will want documentation to show that you made a defensible effort to assess the threat" ("Forms for Comprehensive

[40] I was not able to find out what this means.
[41] Twenty pages of forms

Threat Assessment Guidelines," n.p.) The second statement may reflect the dubious necessity of gathering data on students for the purpose of predicting (and preventing) acts of violence. Since, as the previous chapter demonstrated, there is no current predictive analytic for determining which students may be likelier to commit these acts, the documentation may function as a means of demonstrating due diligence by school districts.

Although these forms may be perceived by some to be mere record-keeping, the collection of so much data on students has resulted in protest by advocacy groups. Much of the data likely to be collected by these forms is sensitive in nature. For example, when screening students for MH concerns, the form directs an interviewer to ask, among other questions:

1. Have you had any unusual experiences lately, such as hearing things that others cannot hear or seeing things that others cannot see?
2. Have you felt like someone was out to get you or wanted to harm you? Have you had any other fears that seem strange or out of the ordinary?
3. Do you have any abilities or powers that others do not have, such as ESP or reading minds?
4. Have you felt numb or disconnected from the world, or like you were somehow outside your body? ("Forms for Comprehensive Threat Assessment Guidelines," n.p.)

Answers in the affirmative to these questions may result in the student being labeled with "psychotic symptoms" of a mental disorder, according to the form (n.p). Once this data exists, it must be reported to the school district superintendent, shared with the multiagency network, and contained in the state's data repository. As advocacy groups have noted, there are no deletion or expiration dates on this data, meaning that the state can possess even inaccurate data in

perpetuity (i.e., Schaffhauser, 2019). In the above example, a student at the K-12 level who answers affirmatively to a question like those above could be labeled psychotic and subjected to MH surveillance and contact with law enforcement even as an adult.

The threat assessment interview for students who may have MH concerns contains questions that ask about more than "psychotic symptoms." The interview form also includes sections on stress and trauma, mood, including sections on self-harm and suicidal ideation, and bullying, in addition to sections on access to firearms and previous violent acts. Requiring threat assessments of students who report self-harm, suicidal ideation, or that they have been bullied implies that the state (and by extension, the school district) views these groups of students as potential threats to public safety due to their MH condition. The inclusion of bullying in this interview has been called out by the director of the Future of Privacy Forum's Education Privacy Project, who reasons that students may be less likely to report bullying if they know that they will be threat-assessed. If a "bullied student [indicates feeling] like there is no solution to the problem or is contemplating revenge," for example, the TAT may recommend that the school district take additional disciplinary action regarding the student (Schaffhauser, 2019). The interview procedures include no such guidelines for students who are accused of bullying.

These concerns also manifest in public media coverage of MH plans and their practices for determining and implementing MH referrals. The Comprehensive School Threat Assessment Guidelines do not require a parent or guardian of a student to be present when these MH assessments are conducted. Given the consequences of answering these and other questions in the affirmative during an MH interview, (I think) a parent or guardian should be present. However, as the *Tampa Bay Times* (2019) reports about commitment of students under the Florida Baker Act (Chapter 394), "In more than two-thirds of those cases, [officers] didn't talk to

parents until after they'd decided to use the Baker Act and sent the child to the hospital." According to the same *Tampa Bay Times* (2019) investigation, officers and school districts do not contact parents due to a "concern that parents will show up at the school angry". Compounding the issue of MH interviews is who is allowed to conduct them. While SB 7026 mandates that TATs are required to include an MH professional as well as a member of law enforcement, Chapter 394 allows the commitment of students without the presence of a counselor or social worker. The gap between the two acts means that students can be involuntarily committed based on the judgement of school personnel or law enforcement without MH training[42].

Of all the stakeholders involved in the creation of the MH plans, no one is more unsatisfied with their content than a grand jury appointed by the legislature. In Florida, a grand jury was appointed on February 13th, 2019, to overview what the suit calls systematic failures among school district administration to comply with the mandates of SB 7026 ("Petition for Order to Impanel a Statewide Grand Jury," 2019). The first report of the grand jury, published on July 19th, 2019, calls the attempts of school district administration to place responsibility for these systematic failures on increased costs associated with compliance and shortages of qualified employees "wholly unpersuasive" (p. 1). The grand jury writes in this first interim report that school district personnel have had 497 days to implement SB 7026 and 72 days to implement SB 7030; this time is deemed sufficient for districts to bring procedures into compliance with the law. The second interim report submitted December 11th, 2019, details what this lack of compliance may entail: radio/communication failures, oversight and sanction authority, charter schools, the Florida Guardian program, and School Environmental Safety

[42] Except in Pinellas county, where only MH professionals can decide to involuntarily commit a student.

Incident Reporting (SESIR). Regarding oversight of MH plans, the grand jury (2019) finds it necessary to “designate an agency to monitor and supervise compliance” (p. 4). Apparently, school districts “cannot reasonably be expected to self-report all potentially damaging information about their own deficiencies” (p. 4). The report calls out Broward and Miami-Dade school districts in particular for allegedly not reporting accurate SESIR data, or, as the legislature describes, “[becoming] experts at data manipulation” (p. 10). The grand jury (2019) alleges that Broward school district personnel were using alternative disciplinary practices in order to reduce the number of SESIR incidents to be reported to the state. In particular, the grand jury uses the example of a teacher who reported a student for disciplinary action but was told that the "perpetrator," in the grand jury’s words, could not be disciplined because of their disability and was "allowed to remain in the class without consequence and continue disrupting the learning environment of the other students" (p.10-11). This example may imply that the grand jury feels that students with disabilities (or as they term them, “perpetrators”) should be reported to the DOE and thus labeled potential threats.

The grand jury report also calls out Miami-Dade district schools for changing the criteria under which they report student data to the DOE. The school district allegedly adopted the practice of not reporting students to the DOE for “pushing, shoving, or other altercations that stop upon verbal command” (2019, p. 11). The grand jury finds fault with this practice, calling it “intent to impair a current or even an imminent law enforcement investigation” and thus a crime (p. 11). The report recommends the indictment of school district personnel who have allegedly engaged in “evidence tampering or obstruction,” a statement that suggests that every SESIR incident is a crime. Indeed, the grand jury recommends that SESIR reporting guidelines should be rewritten in line with Florida’s criminal codes. The threat to indict school district officials for

their behavior was, however, not supported by the Florida legislature in its most recent (failed) addendum to the MSDHSPSA, SB 7040.

In this chapter, I draw connections between the dominant narratives in MH legislation and the MH plans that school districts submitted in response to the MH legislation. Doing this work allows me to trace the ways that dominant narratives can become material, especially as policy documents demand that students be reported to the state on basis of the MH condition, among other reasons. By identifying the dominant narratives from MH legislation in MH policy, I support my argument that MH legislation constitutes state-wide surveillance and control over individuals with MH concerns. The remaining sections find evidence of dominant narratives of MH within the 71 MH plans submitted in 2018. I use the concepts developed in the previous chapter to identify these narratives and explain the connections between legislation and policy. I then use stylometric text analysis to support my reading of these MH plans through calculating cosine similarity, which indicates that MH plans are similar to MH legislation. The conclusion of this chapter finds both qualitative and quantitative connections between state legislation and school districts' MH plans.

Research Questions

This dissertation focuses on three primary research questions:

1. How has MH legislation in Florida addressed the risk of dangerous behavior from individuals with MH concerns? How has the perception of "dangerous" behavior resulted in increased institutionalization of individuals with MH concerns?
2. How does MH legislation in Florida include dominant narratives about people with MH concerns?

3. To what extent are dominant narratives about MH present in school districts' MH plans? How do dominant narratives influence the creation of comparative analytics that label students with MH concerns as potential threats?
4. How can school district's MH plans avoid the implication that students with MH concerns are potential threats? How can school district's MH plans break the misconnection between academic achievement, MH, and the potential for violence?

In the previous chapter, I addressed the first research question through a close reading of SB 7026 and Chapter 394. I build on this close reading by locating the same dominant narratives within school districts' MH plans. Then I use stylometric text analysis in R to attribute the dominant narratives in MH plans to MH legislation via cosine similarity analysis, reinforcing my assertion that the state legislature is constructing students with MH concerns as threats to public safety.

Comparative Analytics and Predictions about Behavior

Analytic tools help make comparisons between texts to determine the similarity of texts based on their characteristics. Similarities are identified when analysis shows that one phenomenon predicts another; in this project, when information that school districts are able to collect about students is combined to make an inference about their tendency to have MH concerns. Multiple companies claim that such analytics are key to making schools safer. Advocacy groups, however, have noted that no causal evidence exists to link individuals with MH concerns with the threat of violence. Technology advocates, including companies that sell predictive analytic solutions, make claims that technologies will reduce violence in schools. In an article for a technology news company, Lynch (2019) identifies three machine learning companies working toward the

goal of "[giving] one hope that mass shooting will soon be a thing of the past or at least very difficult to actuate," (n.p.). The companies overviewed in the article are focused on predictive site security measures. Other analytics companies utilize publicly available datasets (TG Marketing, 2018) to make inferences about student disciplinary incidents. Still other companies call for the release of private MH data on students. One such company, for example is *The Safe Campus* (n.d.) a Blue Light[43] project, explains that it was developed in response to the "Parkland School Shooting" and constitutes a "platform of proven, cutting edge, out of the box technologies that, when combined, provide schools with a powerful picture of threats against students, parents, facilities and educational staff and the ability to remain vigilant against new threats as they emerge" (n.p.) An 18 page white paper published by the company's CEO to discuss its technology states that "[44]It is foreseen that more and more parents and students are going to opt for more transparent access to data in the future" (Parkman, 2018, n.p.). As we have seen before, misconceptions about MH are often used to justify the forfeiture of students' private medical records[45].

Numerous organizations' reports about comparative analytics and school violence cite government documents about school violence. Particularly relevant to this chapter is the FBI's (2018) Phase II study on the Pre-Attack Behaviors of Active Shooters in the United States between 2000 and 2013. One of the report's key findings[46] is that 25% of 63 active shooters in

[43] The Blue Light project is a data analytics company and appears to have no connection to the blue light emergency buttons on school campuses.
[44] The white paper cites a 2004 report by the United States Secret Service and United States Department of Education which states that "A history of having been the subject of a mental health evaluation, diagnosed with a mental disorder, or involved in substance abuse did not appear to be prevalent among attackers. However, most attackers showed some history of suicidal attempts or thoughts, or a history of feeling extreme depression or desperation" (p. 21).
[45] Many of the MH plans spelled HIPAA incorrectly.
[46] This finding is reported commonly; less common is the first finding in the study, that "The 63 active shooters examined in this study did not appear to be uniform in any way such that they could be readily identified prior to attacking based on demographics alone" (p. 7)

the study had been diagnosed with a mental illness and 3 of the 63 active shooters had been diagnosed with a psychotic disorder (p.7)[47]. Sources that rely on this finding note the percentage of active shooters diagnosed with a mental illness as though mental illness is correlated with active shooters. Actually, according to the CDC ("Data and Publications," 2018), an "estimated 50% of all Americans diagnosed with a mental illness or disorder at some point in their lifetime." The National Institute of Mental Health ("Mental Illness," 2019) provides more numbers: that "nearly one in five U.S. adults live with a mental illness," with young adults (18-25) having the highest percentage of mental illness at 25 percent. Another page from the CDC ("Data and Statistics on Children's Mental Health," 2020) discusses the prevalence of mental illnesses seen in children: 1 in 6 children has been diagnosed with a mental, behavioral, or developmental disorder. The World Health Organization ("Child and Adolescent Mental Health," 2020)[48] supports this statistic with their own: 10-20% of children and adolescents experience mental disorders. Without this context, the finding that 25% of active shooters have been diagnosed with a mental illness may seem to suggest that shooters have mental illnesses. However, as these government statistics and government documents acknowledge, the percentage of shooters with diagnosed mental illnesses is approximately the same as in the general population. The very same FBI (2018) report that so many resources on comparative analytics and school shootings cite confirms this information:

> In light of the very high lifetime prevalence of the symptoms of mental illness among the U.S. population, formally diagnosed mental illness is not a very

[47] The report looks at active shooters in general, not just in schools. The 2004 report from the Secret Service and Department of Education uses the statistic that 17% of school shooters had a diagnosed mental illness. This statistic fits within the CDC and WHO percentages for mental illness prevalence in children in the general public.
[48] This same resource was used to justify the creation of *Hope for Healing Florida*, a site examined in the previous chapter.

> specific predictor of violence of any type, let alone targeted violence. Some studies indicate that nearly half of the U.S. population experiences symptoms of mental illness over their lifetime, with population estimates of the lifetime prevalence of diagnoseable mental illness among U.S. adults at 46%, with 9% meeting the criteria for a personality disorder. Therefore, absent specific evidence, careful consideration should be given to social and contextual factors that might interact with any mental health issue before concluding that an active shooting was "caused" by mental illness. In short, declarations that all active shooters must simply be mentally ill are misleading and unhelpful. (p. 17)

Interestingly, many of the reports on comparative analytics that cite this report's 25% statistic do not consider this assertion and continue to propagate "misleading and unhelpful" declarations about the role of mental illness in acts of violence.

In the following section, I build the argument that comparative analytics like Florida's data repository represent another attempt by the state to institutionalize individuals with MH concerns via designation as a risk and increased proximity to law enforcement. I do this work through an analysis of Florida school districts' MH plans, which detail how each school will identity students with MH concerns, collect data about these students, and share this data with the state and district level multiagency network. Combining this information with theories about technology, medicine, and diagnosis, I show how the state's comparative analytic creates the threat it purports to detect. Then I develop my own comparative analytic to quantify the dominant narratives within MH legislation and each school district's MH plan. I do this work because it represents what comparative analytics can do. As the previous section details, comparative analytics cannot currently predict incidents of school violence because no causal

evidence exists to link individuals with MH concerns and their potential to commit acts of violence. However, comparative analytics can determine whether characteristics from a discourse shown to be harmful are present within a corpus of documents. Building from previous chapters, I determine lexical characteristics of dominant narratives and then employ stylometric text analysis in R to quantifiably support my hypothesis that these dominant narratives circulate in MH legislation and policy documents.

Threat Construction

Determining that a student may pose a threat is a complex decision, reliant on multiple factors: behaviors, documents, and interviews. Using comparative analytics allows threat assessment teams to abstract these processes from their environments so that the user sees only the information necessary to make a decision toward some action. For example, I have found that 85% of school districts in Florida rely on early warning systems (EWS) to monitor and in some cases identify students on basis of MH status. Early warning systems collect retention data like high absenteeism, low semester grades in English or Math classes, low standardized test scores, and disciplinary violations (Brundage, 2014)[49]. No Florida law mandates the use of EWS for MH or threat assessment purposes. Florida SB 850, revised in HB 7069, mandates that all K-8 students must be monitored by an EWS, and HB 7069 mandates that the EWS report the number of student suspensions ("CS/CS/SB 850: Education," 2014; "CS/HB 7069: Education," 2017). The association between EWS and its capacity to label students as threats comes from the Florida Problem Solving/Response to Intervention (PS/RtI) Project, a collaborative effort by the University of South Florida and the Florida Department of Education. A fact sheet provided by

[49] This retention data may indicate that a student is, as Jones and Walton (2018) term "materially, socially, politically, and/or economically under-resourced" (p. 242). For example, in Egger et al.'s (2003) study on school refusal, poverty was closely linked to absenteeism.

the PS/RtI project comments that "chronic absenteeism (missing 10% or more of school days) may be one of the first signs of risk for a number of negative outcomes (e.g., academic failure, *anti-social behaviors, mental health problems*)" ("Florida Problem Solving/Response to Intervention Project Early Warning Systems Support," n.d., emphasis theirs). Using the EWS to label students as potential threats separates this data from the action determining that students have "mental health problems" or "antisocial behaviors." According to these documents, identification by an EWS may result in threat assessment at school level, with the potential for students to be reported to the state-level Department of Education.

Used to make a designation about a student's "mental health problems," EWS at school district level mediate diagnosis, standing in for the role of a healthcare provider. The connection between retention data and MH makes an identified student's reality of threat designation and state surveillance more likely. As Braun and Whatmore (2010) note, technologies capacitate connections between realities, impacting agency and embodiment. Investigating technologies encompasses asking questions about the connections they make possible. The PS/RtI factsheet that made this connection[50] does not cite any sources for determining that students with high absenteeism may have "mental health problems" or "antisocial behaviors," or whether those purported problems or behaviors caused the retention concerns. Yet for school districts that use an EWS to comply with SB 7026's mandate to report students whose behavior may pose a threat, the technology produces results that can provoke instant action. Assumed to be an objective

[50] The factsheet may be drawing on school refusal research, or the behavior of children who "stay home from school because of fear or anxiety" (Egger et al., 2003). Egger et al., 2003, is the most highly cited study for school refusal in Google Scholar. The study found that approximately 25% of students with school refusal behavior have at least one mental health concern, compared to 6.8% in the general school population in the study. 6.8% of students with mental illness in the general population is inconsistent with current information from the World Health Organization and the CDC, which was discussed in the previous section. Given more current information about prevalence of mental illnesses in the general population, the prevalence of students with school refusal and mental illnesses may be more consistent with the prevalence of students with mental illnesses in the general population.

algorithm, a black box. In black boxes, Latour (1987) writes that the "accepted statement is...eroded and polished by those who accept it" (p. 42). The lack of evidence made to support the accepted statement of the EWS is concealed by the documents that explain what data goes into an EWS and how retention data is linked to a diagnosis with an MH concern.

Altering Agency and Embodiment

Used to make MH referrals in school districts, EWS hides the indeterminacy of medical diagnosis. While diagnosis usually requires a medical provider[51], MH referrals can be made by any school district personnel. The results of either action are equivalent: threat assessment, reporting the school district, reporting to the state DOE. In this parody of diagnosis, the designation of MH concerns is isolated from the processes by which those concerns were enacted. Mol (2003) examines this isolation in a study on atherosclerosis, where the microscope diagnosis the condition. The microscope, like the EWS, is the technology that facilitates recognition of a condition from symptoms in isolation. Used to render an MH referral, the EWS becomes a tool for constructing the condition it purports to detect. Once diagnosis is made, individuals take on the identity of a person referred for MH concerns. The occlusion of connections by the EWS links students with retention concerns with dual identities as a person with MH concerns and a person who has the potential to threaten campus safety. In this system of alliances, drawing on Barad (2007), technology becomes the instrument used to denote the other (Barad, 2007). The EWS becomes a means of denying that ideas about mental illness are based on dominant narratives. Systems based on dominant narratives continue to marginalize those they enroll.

[51] Yergeau (2018) writes about three types of autism diagnoses: official diagnosis, unofficial diagnosis, and self-diagnosis (p. 163).

As the previous sections demonstrated, identification in school districts leads to threat assessment, bring students already subject to over-policing into more contact with law enforcement. In a reality that conflates an individual's MH concerns with an individual's potential to cause harm, the EWS exemplifies Bennet's (2010) research about systems that are at-once constructed and sustained by their connections. Technology's capacity to facilitate action actually facilitates (mis)identification of students with MH concerns as potential threats to school safety, a (mis)diagnosis that stigmatizes students through their inclusion on the school "watchlist" and in the DOE data repository. Used to stand in for diagnosis constructed by patients and healthcare providers, the EWS replicates dominant narratives about mental illness and violence to produce a result that further marginalizes students at risk. On the "discursive battlefield" of medical decision-making, Teston (2017) writes, humans, representations, analyses, and probabilities are often blackboxed as evidence-based medicine (p. 76). The blackboxing is, as Teston (2017) notes, epideictic (p. 172). The power of the EWS to stand in for evidence impacts diagnosis and marks identified students as deviant, potential threats. Concealing these ableist ideas about mental illness within a blackboxed technology occludes the medical uncertainty of diagnosis.

Technological warning systems and comparative analytics seem objective because they obscure the network of multiple actors that construct the action these technologies facilitate. Yet the supposed objectivity of systems is threatened by socio-historical, racial, and sexual context, as Noble (2018) writes about algorithms. In this way, comparative analytics produce medical evidence, which Teston (2017) writes is the performance of "freeze-framed sociopolitical ideologies, matter, movement, and time" (p. 171). Dominant narratives denote context, or freeze-framed sociopolitical ideologies, as markers of deviancy, and then seek to erase them. The

technologies mandated by SB 7026 and utilized by school districts' MH plans facilitate dominant narratives about mental illness and individuals who are mentally ill. But these dominant narratives intersect with other dominant narratives; retention data about absenteeism, semester grades, standardized test scores, and disciplinary violations is likely to reflect social, economic, racial/ethnic, and gender inequalities (Bécares and Priest, 2015). These inequalities are likely to be rendered deviant as well. For example, in an analysis of writing about school shooters, Price (2011) finds that mental disability is primarily stigmatized, but traits including race, class, religion, and body size are also noted as evidentiary factors in the construction of a violent person (p. 149). Given the ways that dominant narratives about mental illness intersect with those about race (Pickens, 2019), a system intended to enroll those with MH concerns may also enroll others from marginalized groups. The determination of MH concerns and thus potential threat enables discriminatory surveillance over those identified. EWS in school districts and comparative analytics at the state level stigmatize students by designating them as individuals with MH concerns and thus potential threats. In cases of students who may experience MH concerns, seeking MH care may become fraught with the consequence of further surveillance at school district and state level, as well as the stigma of being labeled a potential threat. In this way, the EWS and state data repository become confluent technologies that alter students' agency and embodiment.

Stylometric Text Analysis as Distant Reading

The previous section explored the ways that technologies that purport to improve school safety can be used instead to label students as potential threats and then expose those students to further contact with law enforcement as well as district and state surveillance. These technologies are based on dominant narratives about mental illness and replicate these dominant narratives when

they are used to conflate a designation of MH concerns with a designation of potential threat. In this next section, I build my own comparative analytic to quantify the presence of dominant narratives within MH legislation and school district MH plans. To do this, I first overview existing scholarship on big data research. Then I identify lexical features that denote the presence of dominant narratives about mental illness in texts, before using stylometric text analysis in R to examine the prevalence of dominant narratives within these documents.

In writing studies, computational analyses are often used to expand on qualitative results. In the previous chapter, I employed close reading to identify the dominant narratives circulating within MH legislation. I turn now to distant reading via stylometric text analysis. Drucker (2017) defines distant reading as "the computational processing of textual information in digital form. It relies on automated procedures whose design involves strategic human decisions about what to search for, count, match, analyze, and then represent as outcomes in numeric or visual form" (p. 629). These decisions rely on tokenization and modeling, moves I make based on my identification of dominant narratives via close reading in the previous chapter. Distant reading's emphasis on human decisions that derive the patterns that computers later recognize is useful because this project critiques comparative analytics that do not consider the replication of biases about human nature. This "objective fallacy," as Drucker (2017) writes, is a problem because text analysis is interpretative, "even if running the program becomes mechanistic" (p. 631). Similarly, the previous chapter interpreted dominant narratives about mental illness by illustrating how these narratives normalize the state control of individual with MH concerns. This chapter represents what Drucker (2017) might call "[engagement] in critical conversation about the differences between mechanistic and hermeneutic work as they inform visualizations and data production and influence cultural practices" (p. 634).

Dominant narratives are often implicit; they are replicated in texts because they are unidentified and unquestioned. While scholars in technical communication have conducted textual analysis of dominant narratives, the results of these analyses should be extended to apply to other texts as well. Stylometric text analysis, based on close reading of problematic discourse, can show the prevalence of these dominant narratives within documents outside the initial text sampling. On a related note, Gallagher et al., (2020) note a practical exigence for running computational analyses: that the analysis can aid holistic evaluation, especially of big datasets that "are likely unable to be read closely by a single researcher and even by a small group of researchers" (p. 157). In my project, SB 7026 consists of 105 pages of text; Chapter 394 consists of 102 pages. School districts' 2018 MH plans constitute 796 pages of text. Totaling so many pages, my dataset is unlikely to be read closely, meaning that the harmful dominant narratives therein are unlikely to be identified and questioned. Developing computational methods redresses these concerns.

I am also building this analytic to show how analytics *should* be designed. SB 7026 has contributed to a state-level repository that collects students' names based on faulty indicators about their potential to pose a threat to their schools. These behavioral algorithms become what O'Neil (2016) might term "predictive [models]" based on "faulty, incomplete, or generalized data" that people believe in (p. 22). Yet O'Neil also believes that socially just employment of these models can be implemented by examining input data. Accordingly, this next section details the creation of comparative models, data collection and cleaning, and analysis.

Comparative Model, Data Collection, and Analysis

Making the Comparative Model

I made a comparative model from the dominant narratives in Chapter 394 and SB 7026. To make this model, I selected text from both pieces of legislation that corresponded to the dominant narratives I outlined in the previous chapter. For example, I used text that related to the designation of individuals with MH concerns, including information on consent and competency. I excluded some text; both laws discussed topics that are outside the scope of this dissertation. For example, this dissertation does not discuss the amount of education that an MH provider needs to have in order to meet qualifications to practice in the state of Florida. Nor does this dissertation discuss the procedure for storing firearms removed from the residences of individuals under risk protection orders. I removed text like this because it does not correspond to the dominant narratives studied in this dissertation.

Data Collection

I collected pdf files of 71 school district's MH plans from academic years 2018-2019 from the Florida DOE Office of Safe Schools website: http://www.fldoe.org/safe-schools/mental-health.stml. I converted the pdf files to txt files[52]. I excluded pictures, numbers, and names of school district personnel when possible.

Data Analysis

Given the large quantity of text to analyze, I used the R package Stylo (Eder et al., 2020) to conduct stylometric text analysis. Stylometric text analysis [53]focuses on lexical features that

[52] Two school districts, FAU and Pinellas, submitted pdf files that were not able to be converted to txt files. I instead converted their pdf files to jpegs, converted the jpegs back to pdfs, and performed OCR on the pdfs to be able to convert to readable text.

[53] Stylometric text analysis has often been used to determine authorship. For example, Mosteller & Wallace (1964) used the technique to decide authorship of the Federalist Papers. Thinking through my project, if the state is the

differentiate one text from another (Evert et al., 2017). The equation I chose, Cosine Delta, uses vector analysis to produce a cosine measure of the distance between texts. As the image below shows, this analysis recognizes similarity between texts by calculating the cosine between their different lexical features. In the image below, the cosine of the green vector, Doc1, and the blue vector, Doc 3, will be less than the cosine of Doc1 and the red vector, Doc 2. A smaller cosine indicates a smaller difference (or greater similarity) between documents. A cosine of two vectors that is closer to 0 indicates that the documents are more similar, while a cosine of two vectors that is further away from 0 indicates that the documents are less similar (Data Science Dojo, 2017). Based on these cosine calculations, the R package Stylo will generate a graph that visualizes the connections between documents, or a cluster analysis.

Results

The lexical model and the school districts' MH plans share similar lexical features. This information can be determined based on the cosine similarity measurements between documents, exemplified in the image below. Identified clusters of documents are linked with brackets. The smaller the bracket between two documents, the smaller the difference between the two; greater similarity is indicated by a bracket that is closer to 0. Given the clustering of these documents within 0 and 2, they share similarities.

author of MH legislation, then using stylometric text analysis on school districts' MH plans links the lexical characteristics of the state's dominant narratives with the MH plans created from MH legislation.

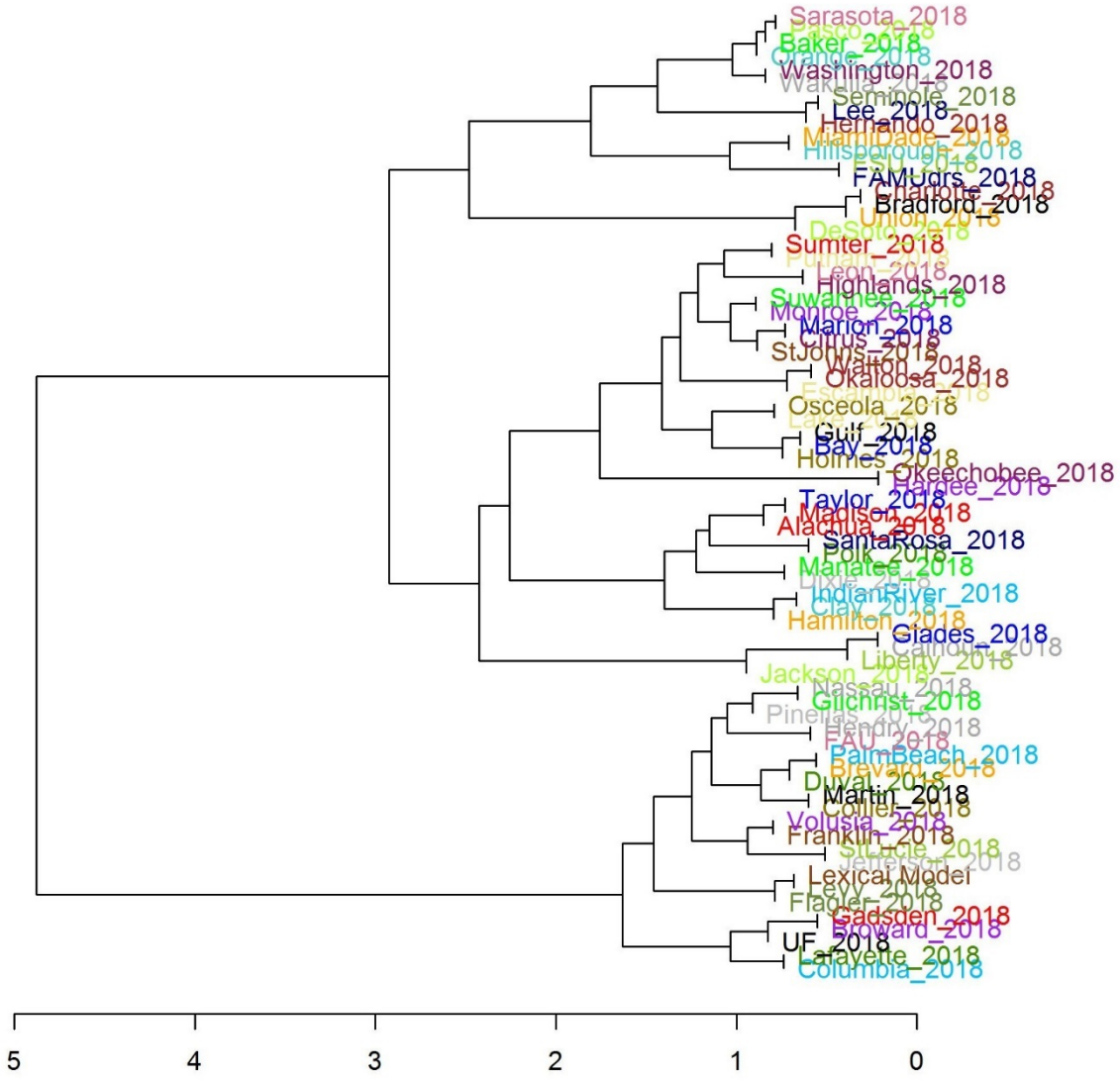

Figure 3: Cluster Analysis of MH Plans and Lexical Model

In the image above, the exact distances between documents are not represented. The visualization is nonetheless useful for understanding that these documents all share similar discursive features, as would be expected from MH Plans mandated under legislation that contains dominant narratives. It is also possible to output distance measures in stylo; I provide the ones that are less than 1, or more similar to the lexical model, in the table below.

Table #1: Measures of <1 Distance between the Lexical Model and MH Plans

School District's MH Plan	Distance from Lexical Model, Representing Cosine Similarity
Levy	0 1.16618527003457[54]
Jackson	0.665752634636881
Brevard	0.67556516532689
Palm Beach	0.69451647263204
Dixie	0.730139150088068
Gadsden	0.752569460922844
Florida Atlantic University	0.777782564431267
Pinellas	0.77930904877619
Florida State University	0.799801075015324
St. Lucie	0.826773741000146
University of Florida	0.830314858650062
Okeechobee	0.844132528831236
Martin	0.860664510735213
Putnam	0.863514695384585
Holmes	0.87572827499174
Collier	0.881299745734606
Broward	0.8841659647696
Suwanee	0.888846949127786
Flagler	0.893219673778892

[54] This output looks like an error, present in multiple analyses. I do not know why. Based on the recurring output errors, I excluded this result from the analysis.

Table #1 (Continued)

Columbia	0.905925269774179
FAMU DRS	0.905925269774179
Charlotte	0.936910600246541
Nassau	0.953753955152959
Gulf	0.960010420749501
Hardee	0.973347162754665
Marion	0.992614297567357
Osceola	0.994936664357191

While all the documents are using the same type of discourse, the school district MH Plans in the above table are using language that is more similar to the lexical model. This result may indicate that the dominant narratives in MH legislation are appearing to greater extent within MH plans that are more similar to the lexical model. There are, however, limitations to this tentative finding: since all the MH plans are similar to the lexical model, judgments about "more similar" and "less similar" are relatively arbitrary. I have chosen 1 as the cut-off for "less similar," but as the creator of the R program stylo, Maciej Eder, (2017) notes, "Although all these solutions are reasonable and theoretically justified, the final choice of the number of features to analyze is *a priori* arbitrary" (n.p.). Results indicate that words that occur at a high frequency within the lexical model also occur at high frequencies within the MH plans, and that the above MH plans have somewhat higher frequencies than others. Eder (2017) defends the results of stylometric text analysis by writing that they give "fairly good insight into variability of the input data" (n.p.). A second possible limitation is that some MH plans sound more similar

to the lexical model because they contain lexical elements that are indicative of legislative discourse but not necessarily indicative of dominant narratives. Testing the arbitrariness of these boundaries then requires additional analysis to examine the degree of similarity I have designated here.

I tested the varying similarities of these results through frequency analysis of n-grams and bigrams. First, I developed a sample of the MH plans most similar to the lexical model (8 plans, 10% of the total) versus a sample of the MH plans least similar to the lexical model (8 plans, 10% of the total). By examining frequencies of n-grams and bigrams at these two "extremes" (most and least similar, keeping in mind that all of these plans are similar), I can determine whether there are lexical differences in the "bags-of-words" that make up each corpus. This technique comes from Juola (2013, July; 2013, August), on determining authorship. According to Juola (2013, August), n-grams and bigrams can lexically distinguish (or determine similarities) between corpora. For this second analysis, I combined MH plans that were 1) most similar to the lexical model and 2) least similar to the lexical model into separate corpora, then compared frequency tests to the lexical model's frequency tests. For these frequency tests, I removed stopwords like "the," "an," or "and" to more easily show similarity of important words present (or absent) from tests. Results of these frequency analyses show that the most common words used in each corpus (lexical model, most similar to lexical model, least similar to lexical model) are consistent. The table below shows most frequent n-grams and bigrams from the analysis.

Table 2: N-grams and Bigrams of Lexical Model, More Similar, Less Similar Corpora

	n-grams, lexical model		bigrams, lexical model		n-grams, more similar		bigrams, more similar		n-grams, less similar		bigrams, less similar	
	term	freq	term	freq	term	freq	term	freq	term	freq	term	freq
1	mental	153	mental health	102	school	863	mental health	624	health	532	mental health	495
2	services	153	the patient	78	health	722	the school	180	mental	522	health services	98
3	school	135	the department	59	mental	674	health services	113	school	510	the school	94
4	health	126	a person	38	students	591	the mental	102	students	320	school based	78
5	treatment	113	mental illness	34	services	473	the district	95	district	176	school district	72
6	patient	111	the child	31	student	283	to provide	89	based	166	for students	61
7	facility	71	substance abuse	29	counseling	224	the student	80	student	137	based mental	51
8	person	68	or adolescent	27	based	218	school based	79	community	127	the district	46
9	department	64	pursuant to	27	district	203	for students	76	behavior	95	the student	41
10	child	59	child or	26	social	198	students who	73	social	95	of mental	39

I have used frequency analysis here to further support the findings of stylometric text analysis. As a sample of the top ten n-grams and bigrams in each corpus shows, these corpora are similar. Top n-grams “mental,” “school,” and “health,” and top bigram “mental health” all appear frequently in each corpus. There are subtle differences between the “most similar” and “least similar” corpora. Higher frequency terms in the most similar corpus indicate an emphasis on MH care: “substance abuse,” “social emotional,” “problem solving.” Higher frequency terms in the least similar corpus indicate an emphasis on schools: “school district,” “school based,” “school counselor,” “social workers,” “school psychologist.” Again, I do not claim that these corpora are distinct; merely that the 8 school districts’ MH plans that are most similar to the lexical model

contain higher frequencies of terms that are more indicative of MH care, aligned with MH legislation. Similarly, the 8 school districts' MH plans that are least similar to the lexical model show subtle differences from that lexical model. Analyzing the slight divergences between these two "extremes" against the lexical model shows how consistently similar to MH legislation these MH plans are.

This adventure in stylometric text analysis results in two key findings: 1) that MH plans are similar to MH legislation; and 2) comparative analytics are used to support interpretation of data variables in ways that can marginalize students. To understand the similarity between documents, I calculated the cosine similarity between the lexical model of MH legislation and school districts' MH plans. Cosine similarities indicated that the MH plans were similar to MH legislation, indicating that the dominant narratives in MH legislation are indeed circulating within the documents mandated by that legislation. To test the extent to which these dominant narratives are present within MH plans, I analyzed the differences in frequencies of n-grams and bigrams between 10 percent of MH plans that were the shortest distance from the lexical model (i.e., the most similar) and the 10 percent of MH plans that were the further distance from the lexical model (i.e., the least similar). I found that some differences existed between frequencies at this level, supporting Eder's (2017) assertion that while the choice of features to analyze is fairly arbitrary, the analysis can yield results.

The second finding of this section operates as a cautionary tale about comparative analytics: that comparative analytics can determine variability between groups but cannot assign meaning. For example, based on the results above, I could have made the argument that school districts' MH plans that were closer to the lexical model, with scores of 1.0 or below, contained the highest prevalence of dominant narratives. I supported this 1.0 cut-off with frequency

analysis, which indicated that MH plans on one side were more similar to the lexical model, while MH plans on the other side were less similar to the lexical model. Based on this second analysis, I could have argued that certain MH plans were most culpable of perpetuating dangerous ideas about MH among students. This argument is persuasive; supported by quantitative data. However, the argument also obscures the arbitrary nature of the results. Comparative analytics make these same arguments, deeming that based on behavioral frequencies, creating a role for the reader to play in determining mental health of students. That role is further utilized in order to harm students through conflation of mental illness and the potential for gun violence. While my comparative analytic about the dangers of dominant narratives was supported by the evidence in the previous chapter, the comparative analytics that label students as threats are based on no such causal evidence, as the previous sections in this chapter demonstrate.

As previous sections of this chapter demonstrated, numerous advocacy groups have indicated their suspicion about the capacity of comparative analytics to label students as threats based on behavioral data including absenteeism, semester grades, standardized test scores, disciplinary data, mental health information, and social media posts. Understanding dominant narratives helps us understand why comparative analytics have been promoted as a solution to the problem of violence in schools. Dominant narratives about MH construct individuals with MH concerns as deviant; other. Given distinctions, a computer can sort data into categories. Computers are good at doing this. The categories are the problem; in the case of school violence, the categories lack causal evidence for their existence. Even given evidence for existence of categories, as my example above shows, the final determination that makes a student into a

student with MH concerns and/or threat is a human's responsibility. In this I am reminded of Drucker (2017), who writes about distant reading:

> Machine reading only performs on the literal text, even if inferential, probabilistic, and other techniques are used to create association among the orthographically inscribed textual elements. The issue is not whether a computer can read as well as a human being can but whether a computer will ever be able to read as badly as a human being can, with all the flawed dynamism that makes texts anew in each encounter. (p. 631)

Based on causal evidence for the association to be made between behavioral frequencies and potential threat, comparative analytics may be able to identify individuals whose behavior may warrant concern. In this vein, the next section examines the texts identified by my comparative analytic in search of dominant narratives.

Dominant Narratives in MH Plans

The previous section identified similarities between all MH plans and MH legislation, indicating that MH legislation's dominant narratives are present within MH plans. Some MH plans contain language that is more similar to MH legislation than others, so in this section, I examine these MH plans in search of the dominant narratives the previous chapter identified. The goal of this section is to understand to what extent dominant narratives occur in policy documents and whether their usage differs from MH legislation. I examine the MH plans of these school districts: Jackson, Brevard, Palm Beach, Dixie, Gadsden, Florida Atlantic University, Pinellas, Florida State University, St. Lucie, University of Florida, Okeechobee, Martin, Putnam, Holmes, Collier, Broward, Suwanee, Flagler, Columbia, FAMU DRS, Charlotte, Nassau, Gulf, Hardee, Marion, and Osceola. These school districts' MH plans were identified by the previous section as

lexically more similar to the model created from MH legislation. I closely read these MH plans in search of the features of these dominant narratives, established in the previous chapter: 1) Individuals with MH Concerns Should Be Identified; 2) MH Concerns Should Be Identified by Behavioral Signs and Symptoms; 3) MH Education Should Help Individuals Identify MH Concerns; 4) MH Concerns Should Be Addressed by MH Treatment; 5) Individuals with MH Concerns Should Access MH Evaluation and Treatment; 6) The State Should Mediate MH Evaluation and Treatment.

Dominant Narrative #1

School districts comply with SB 7026's mandate to identify students with MH concerns, evoking the dominant narrative that these students are able to be differentiated from their peers. In many cases, schools employ EWS data to identify students who may have MH concerns. 24/26 (92%) of the MH plans in this sample, and 60/71 (85%) of all MH plans, use EWS data. While some school districts (in this sample: FAU, Broward, Suwanee) use EWS data to measure the efficacy of the services provided, the other school districts identify individuals who may need MH services based on attendance, academic achievement, and disciplinary information. Students are also identified as individuals with MH concerns when they or their parents inform the school district that they have received MH services previously, or when students seek MH services from school counselors. In school districts, EWS use seems to be a way of implementing universal screening among students. One school district explains that EWS data is an "objective" part of the referral process ("Electronic SOC Referral and Case Management System," Nassau MHAAP, n.p.). While EWS data is likely to provide results about variability between groups of students, as previous sections have showed, those results may not indicate that the individual has an MH concern, or that the individual may present a threat to the school district.

Dominant Narrative #2

In addition to EWS data, MH plans also detail the intent to identify students by their behavior. These behaviors can include signs of substance abuse, as well as social, emotional, or behavioral concerns. These concerns then become the nonnormative behaviors disciplined through MH identification. Teacher and administrator observations, or student support teams, can also identify students who have not been identified by the EWS but are seen to be "at-risk," for MH concerns. Multiple school districts illustrate their intent to use "resiliency" measures to screen students. As one school district describes their resiliency screener, "this screener tool will assist in detecting social emotional deficiencies and includes resiliency curriculum designed to target identified social emotional needs of students" (Brevard MHAAP, p. 3). In some cases, students can be identified by perceptions about their "connectedness[55]" to the school and overall well-being. School district personnel determine these perceptions by surveying students, an extension from the dominant narrative. While in MH legislation, the dominant narrative is that MH concerns can be identified through behaviors, MH plans seem to suggest that MH concerns can be identified through students' written answers to survey questions[56].

Dominant Narrative #3

In MH plans, school districts report the various MH education programs that their district offers or intends to offer. School districts all over different types of MH education, but, as with MH legislation, not many schools are able to link MH education practices with specific program outcomes for the alleviation of MH symptoms, or the facilitation of access to MH evaluation.

[55] Multiple school districts' MH plans use this word. According to the CDC (2018), school connectedness is "the belief held by students that adults and peers in the school care about their learning as well as about them as individuals."

[56] FAU uses a self-reporting tool to measure "covitality," based on questions about "belief-in-self (self-awareness, persistence, and self-efficacy); belief-in-others (school support, family coherence, peer support); emotional competence (empathy, self-control, and behavioral self-control); and engaged living (gratitude, zest, and optimism)" (p. 22).

These programs are supposed to be "evidence-based and developmentally-matched prevention curricula in the general education setting, including social-emotional learning and mental health literacy curricula," ("An Overview of School-Based Mental Health Services," n. p.). Some education programs seem to be used across multiple districts. These include the Sandy Hook Promise, a "proven, evidence-informed Know the Signs" program ("About Us," 2020). Multiple school districts also use Sanford Harmony, which teaches "social emotional learning," that according to the website positively influences academic performance and graduation, and reduces conduct problems, sexually transmitted infections, pregnancy rates, mental health disorders, and involvement in the justice system ("What is SEL?" 2020). In one school district, the Florida Fishing Academy's program Angling for a Health Future is presented as an example of social emotional learning (Palm Beach MHAAP, p. 20). In other cases, MH plans present safety, personal fitness, teenage parenting, DARE, health education, afterschool programs[57], and music therapy programs as examples of the MH education that their districts can provide. The discrepancies between these purported MH education programs may indicate that while MH education is viewed as necessary to recognize MH concerns, what counts as MH education varies greatly.

Dominant Narrative #4

MH plans conform to the dominant narrative of MH treatment by including provisions for "mental health assessment, diagnosis, intervention, treatment and recovery[58]." The prevalence of this phrase comes from the document "A Framework for Safe and Successful Schools," developed for school districts implementing SB 7026. To receive the MH allocation from the

[57] Not in the sample, but the Bay County District Schools uses the local Girl Scouts' council's Get Real curriculum as an example of the district's social emotional learning programs ("Includes description of supports that addresses mental health needs," n.p.).
[58] This phrase occurred in most MH plans, in line with the receipt of the state MH allocation.

state, a school district must demonstrate use of an evidence-based process for redressing students' MH concerns ("A Framework for Safe and Successful Schools," n. p.) Referring to mental illness diagnosis as something to be intervened in and recovered from others the individual who has received the diagnosis. Mental illness becomes a deviation that the student should eliminate. For one school district, "**If** the student's mental health or substance abuse issues reflect two or more hospitalizations or he/she has failed to respond to the interventions and services provided at Tier 3, the student will be referred to the Crisis Action Team for more intensive wraparound services" (Jackson MHAAP, "Evidence-Based Mental Health Services for Students," n. p., emphasis theirs) The wording here implies that the student has the responsibility to respond to interventions and services; failure is on them.

Dominant Narrative #5

As in MH legislation, MH plans present MH evaluation and treatment as a given process that individuals with MH concerns should enter. Those identified under the MH plan become patients who must receive some type of treatment in order to eliminate their symptoms and/or their presumed capacity for violence. MH plans, however, enter the conversation about competency and consent in different ways because they detail processes for minors. Parents and/or guardians are asked to participate in the MH evaluation and treatment processes. Many school districts' MH plans include supplemental forms for the parent/guardian to complete so that school districts can access information about the child's medical records from their primary care provider. In some cases, parents/guardians have the right to refuse consent to share medical records, as well as decline to have their child screened for MH concerns. One school district's MH plan in the sample details the process the school will follow if a parent[59] "declines counseling and/or

[59] This particular page uses only the word "parent," with no mention of a guardian.

consent to share information" (Martin MHAAP, p. 21). The school may then consider notifying the SRO and the School Social Services Worker, the latter of whom will perform weekly or biweekly checks on the family. As the school notes in red text, "As is required by law if any student presents as abused or neglected staff is required to report" (p. 21). Nor is this particular school district alone in discussing parental refusal to consent in conjunction with abuse reporting procedures[60]. In keeping with the dominant narrative that expects MH evaluation and treatment in response to MH concerns, refusal to participate in the process is construed as deviant. As one school district's MH plan explains, "While parent/guardian(s) are not required to disclose pertinent medical information, there is an expectation (best practices) that this information will be shared with the school district and mental health counselors and solely for the purpose of case coordination, service delivery and continuity of care to all eligible students" (Putnam MHAAP, p. 7). Parents/guardians who decline to disclose their child's medical information are deemed to not be following best practices. In some school districts, parents/guardians who refuse to consent may be opened to allegations of child abuse.

Dominant Narrative #6

SB 7026 requires a school safety officer to be present in each school; in keeping with the dominant narrative that the state should mediate MH evaluation and treatment. School districts' MH plans detail the use of these and other agents of the state, responsible of identifying,

[60] Not in the sample, but Jefferson's MHAAP states, "Our School will obtain a signed copy of the Consent for Mutual Exchange of Information Form to ensure that the parent is complying with the treatment plan (required visits) prescribed by the child's doctor (pediatrician or psychiatrist). Our School will offer information to the treating doctors on the student's behavior and progress to assist the doctor with his interventions. Our School will hold a Parent Conference to discuss the benefits of the treatment on the overall academic and behavioral wellbeing for their child. If our School suspects child abuse, abandonment or neglect, according to Florida Statutes (section 39.201(1)(a), F.S., "Mandatory reports of child abuse, abandonment or neglect") require that any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare must report such knowledge or suspicion to the Florida Abuse Hotline" (p. 14).

evaluating, and acting upon students with MH concerns. Law enforcement officers are also present on school districts' Threat Assessment Teams. In most cases, law enforcement officers are still the main personnel to carry out the Baker Act, or the part of Chapter 394 that allows for involuntary commitment. Multiple school districts reference the Baker Act in MH plans; unsurprisingly, a student's involuntary commitment identifies them as person with MH concerns. After the student's involuntary commitment ends, return or re-entry procedures are detailed in MH plans. One school district's MH plan explains that after "[evaluation] by law enforcement," a student may be taken to a facility for evaluation; before the student can return to school, the school must "[receive] a document from the facility indicating that the student is now fit to attend school" (Gadsden MHAAP, p. 16). Other school districts mandate school safety plans in response to a student returning from involuntary commitment. Under one school district's MH plan, the Baker Act policy constitutes "collaborative partnerships with Department of Juvenile Justice (DJJ) and Baker Act receiving facilities at the school level" (Nassau MHAAP, "School Climate Transformation Team," n. p.). The combination of the Department of Juvenile Justice and the Baker Act in the same sentence may imply that students who have been involuntarily committed are offenders. So too, the school functions as an agent of the state in identifying students with MH concerns for evaluation and treatment. The consent forms that parents are given to sign releasing student medical information makes schools the hubs for multiagency information regarding student's MH status.

Conclusion

Stylometric text analysis of MH plans indicates that the dominant narratives from Chapter 394 and SB 7026 circulate within district-level policies and protocols. Dominant narratives about MH can be particularly harmful at this district-level, considering that schools under SB 7026 are

encouraged to identify, threat-assess, and report identified students to a state-level data repository, a repository that has no deletion or expiration guidelines. School district MH plans contain dominant narratives in similar amounts, according to cosine similarity analysis. To support cosine similarity analysis, I also ran frequency analyses of n-grams and bigrams within the 10% of MH plans that were most similar to the lexical model of dominant narratives and the 10% of MH plans that were least similar to the lexical model. The differences between the most and least similar MH plans were subtle but present; supporting the findings of cosine similarity analysis. At district-level, dominant narratives present students with MH concerns as deviant individuals who must access MH treatment so that they can recover or "return to normalcy," as multiple school districts' MH plans state[61]. MH plans identify students based on multiple indicators and subject those students to behavioral and disciplinary monitoring. Parents/guardians are expected to consent to this monitoring by sharing children's medical records and allowing medical providers to communicate directly with school personnel. Parents/guardians who decline this information sharing are similarly construed as deviant from best practices and in some school districts may be opened to allegations of child abuse. In this way, the predictions made by analytics correspond to Zuboff's (2019) critique of surveillance capitalism. Behavioral data is "fabricated into prediction products" and "sold in behavioral futures markets" (p. 8). Zuboff (2019) questions comparative analytics because they separate an occurrence or occurrences of human experience from human judgement of that experience. In this way, comparative analytics transform data about individuals MH concerns into a label about that person's potential to commit violence. They transform students into threats. As previous

[61] This statement appears to be based on a quote from the National Association of School Psychologists, 2019, describing the role of psychologist in facilitating a "return to normalcy" for students in a school after a crisis. The original statement does not appear to apply to the individual MH treatments of students, as it is used in multiple MH plans.

chapters have noted, attitudes about individuals with MH concerns are based on a long history of these individuals' institutionalization and stigma, promulgated by dominant narratives about MH. The dominant narratives perpetuate the stigma of MH concerns through MH plan's identification, evaluation, and monitoring of students.

In this chapter, I addressed my third research question through stylometric text analysis of 71 school districts' MH plans. In the next chapter, I answer my research questions by addressing the ways that historical perspectives on individuals with MH concerns contribute to their continuing stigmatization. I then explain the ways that stigma is perpetuated within dominant narratives about MH and the MH legislation that circulates those narratives within public policies. Finally, I determine how stigma manifests through the construction of individuals with MH as deviant, dangerous, or potential threats to public safety.

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Chapter Five: Conclusion

In this project, I have found that MH legislation reinforces misconceptions about mental illness and increases stigma against individuals who may need MH care. MH legislation acts this way because it normalizes a particular response to these individuals, requiring individuals with MH concerns to access MH treatment. This response brings adverse consequences along with it, among them identification, disciplinary measures, and exposure to law enforcement. MH legislation presents MH treatment as a way of solving the problem of MH concerns. However, as I note in Chapter 3, MH treatment is not always a cure for MH concerns. Indeed, as disability scholarship informs us, many MH concerns are recurrent and cannot be cured (Price, 2011). When individuals with MH concerns are exposed to this dominant narrative of medical progress, they are expected to act within its parameters. Yet as I find in Chapter 4, the varieties of MH treatment available to students may not be varieties that they find useful. For example, some school districts list programs like participation in Girl Scouts as a potential MH activity. While the Girl Scouts of the USA assert that participation in social activities can support girls and combat loneliness ("Girls Are Having a Mental Health Crisis—Some Solutions, Though, Are Simple," 2020), the organization does not identify itself as a type of MH treatment. When individuals with MH concerns are not perceived to improve under MH treatment, whatever that treatment consists of, they may be labeled as noncompliant. As I find in Chapter 3, noncompliance manifests in disciplinary measures like return-to-school plans that require students returning from involuntary MH examination to operate under enhanced scrutiny from school personnel. Or, as I find throughout this dissertation, discipline also includes exposure to law enforcement, who perform the majority of transfers for involuntary examination (Shapiro,

2020). All these consequences connect to reinforce the misconception that individuals with MH concerns are more likely to be dangerous and should be monitored to protect public safety. This misconception, as well as the very material risks of involuntary examination, school disciplinary measures, and exposure to law enforcement, increase MH stigma against individuals with MH concerns.

Most people with MH concerns are not violent. Yet as I maintain in Chapter 2, legislators perpetuate this misconception when they argue that increased MH legislation will be an effective response to the crisis of gun violence in schools. MH legislation that mandates school districts identify and threat assess students with MH concerns further reinforces this misconception, especially when it intersects with existing MH legislation that recommends that these individuals be removed from schools pending MH examination. Given that law enforcement perform many of these transfers to involuntary examination, the public may view police presence as necessary to redress the threat posed by these individuals. Unfortunately, increased police presence toward individuals with mental illnesses can result in increased risk of injury or death. For example, a report by the Treatment Advocacy Center notes that "a minimum of 1 in 4 fatal police encounters ends the life of an individual with severe mental illness" (Fuller, Lamb, Biasotti, & Snook, 2015, p. 1). Normalizing the misconception that individuals with MH concerns are responsible for gun violence also normalizes the social response to these individuals, additional policing and law enforcement surveillance.

MH legislation's requirement that school districts identify students with MH concerns normalizes metrics for determining whether that student has MH concerns. As I find in Chapter 4, these metrics are not likely to correlate with either MH concerns or students' potential to engage in violence, but they are likely to correlate with a student's lack of privilege. For

example, labeling a student as antisocial based on their absenteeism risks further marginalizing students of color, or students who are economically disadvantaged. As a report from the Brookings Institute (2017) finds, these two demographic groups are most likely to have high rates of absenteeism. Nor am I alone in pointing out that MH legislation has the potential to further marginalize at-risk students; as I note in Chapter 4, this speculation is borne out by organizations including the Southern Poverty Law Center and ACLU. Deployed in this way, MH legislation contributes to labeling already marginalized students as mentally ill and potentially violent, therefore increasing students' contact with law enforcement that may respond to them as the threats they are labeled to be.

In this dissertation, I asked and answered three research questions.

1. How has MH legislation in Florida addressed the risk of dangerous behavior from individuals with MH concerns? How has the perception of "dangerous" behavior resulted in increased institutionalization of individuals with MH concerns?
2. How does MH legislation in Florida include dominant narratives about people with MH concerns?
3. To what extent are dominant narratives about MH present in school districts' MH plans? How do dominant narratives influence the creation of comparative analytics that label students with MH concerns as potential threats?

First, MH legislation in Florida has addressed the risk of dangerous behavior from individuals with MH concerns by transferring these individuals for involuntary mental health examination. By presenting Mental Health as a problem that can be solved through the Baker Act (the section of the Florida Mental Health Act that allows an individual to receive involuntary MH examination), MH legislation presents the risk of dangerous behavior by individuals with MH

concerns as a problem that can be solved by identifying abnormal behavior and then calling for agents of the state to address the issue. Presenting MH as a problem that can be identified also designates individuals with MH concerns as abnormal. Reinforcing definitive binary assessments of ab/normalcy ignores the multiple ontologies of mental illness. MH legislation normalizes the misconception that mental ability and disability are binary states that can be easily identified based on external signs or behaviors.

MH legislation also presents the risk of violence from individuals with MH concerns as a certainty. Thus, MH legislation normalizes the role of law enforcement in responding to individuals with MH concerns, implying that individuals with MH concerns are threats to public safety. The symbolism of law enforcement personnel responding to MH cases reinforces the perceived danger of individuals with MH concerns. Those who call for additional MH legislation in the wake of gun violence tragedies further imply that individuals with MH concerns are responsible for gun violence. These actions intersect with historical public attitudes toward mental illness and institutionalization. As Chapter 2 finds, after the Community Mental Health Act of 1963 mandated deinstitutionalization, the long-standing perception was that while MH institutions closed, additional funding for MH care did not materialize. Public perception was that individuals with MH concerns were released into the community without access to treatment (Torrey, 2013). Potentially due to this connection between mental illness and institutionalization, MH legislation presents a solution to the issue; it facilitates the return of individuals with MH concerns to facilities for MH evaluation and treatment.

Second, Mental health legislation in Florida promulgates several dominant narratives about mental illness and the risk that individuals with MH concerns pose to public safety. Based on the perceived risk of individuals with MH concerns, MH legislation suggests that these

individuals be referred to MH treatment in order to alleviate their risk. As I remind readers at multiple points in this dissertation, most individuals with MH concerns are not violent. In Chapter 4, for example, I note that percentage of violent acts committed by individuals with MH concerns is roughly similar to the percentage of individuals in the general public with MH concerns. The similarity suggests that individuals with MH concerns are statistically no more likely to commit violent acts than their peers in the general public. Yet their risk remains, built on dominant narratives that facilitate identification, examination, and treatment in order to address their perceived threat to public safety. MH legislation mandates that individuals with MH concerns be identified in order to protect public safety. The necessity of identification functions as a way of disciplining students for presenting behaviors that are perceived to be abnormal. As Chapter 4 finds, these behavioral signs and symptoms are not always correlated with mental illness. Instead, this dominant narrative marks students as deviant others who need to be threat-assessed.

Dominant narratives about MH promote the idea that MH evaluation and treatment will address MH concerns. These dominant narratives are reinforced by both MH protocols and education, which recommend access to treatment. Access to treatment, however, is not always an effective way to address MH concerns. As Chapter 2 and Chapter 4 detail, many children who are transferred for involuntary MH examination are not actually referred for MH treatment. Instead they are hospitalized for examination and then returned home. Unfortunately, most MH plans detail that children must complete a return-to-school plan before they can resume their education. While the dominant narrative promotes access to treatment as the solution to individuals with MH concerns, in practice this narrative causes educational disruptions for children, increased exposure to school personnel, and other stigmatizing consequences. The

discrepancy between the promise of the dominant narrative and its impacts is influenced by an inept understanding of mental illness. The narrative of medical progress begins at diagnosis and concludes upon recovery. But this narrative is not often supported by many individual's lived experiences with illness. Thinking of MH treatment as a convenient plot device to facilitate recovery may make a good narrative, but, as Chapter 3 shows, actually harms individuals whose experiences run counter to the dominant narrative. Not all mental illnesses (or broadly, not all illnesses) are able to be resolved through treatment. Or, for additional context, sometimes the MH treatment that individuals are able to access is not the most useful treatment. Multiple chapters in this dissertation reference ineffective treatment options available within Florida's MH institutions. Additionally, in Cannon & Walkup (2021), I discuss a type of MH treatment that residents of a Florida facility did not find useful for navigating their conditions. The dominant narrative that MH treatment will alleviate MH concerns continues, however.

Third, dominant narratives about MH identification and institutionalization are present in school districts image plans as MH plans attempt to answer the directives of MH legislation. The components of MH plans are mandated by MH legislation. As Chapter 4 establishes, many school districts identify students with MH concerns based on flawed metrics. School districts' use of EWS encourages comparative analytics that enact the work of MH identification. 85 percent of Florida school districts' MH plans list EWS as a means for school personnel to identify students with MH concerns. EWS are meant to identify students who may be at risk for retention and/or graduation, but these metrics are not correlated with either mental illness or the risk of violent behavior. The use of EWS to label students with MH concerns is, as Chapter 4 notes, problematic and likely to result in further marginalization of already vulnerable students. The potential for marginalization is also codified at several points within school district level

MH plans. For example, Chapter 4 finds that MH plans also attempt to govern children's guardians by requiring that they cooperate with the school district to share information regarding the student. These dominant narratives perpetuate the stigma of MH concerns through MH plan's identification, evaluation, and monitoring of students.

Intervention

In concluding this dissertation, I detail potential points for intervention in the creation and revision of school districts' MH plans. School districts' MH plans represent an optimal place for intervention because revising these protocols will alleviate the immediate impacts that these documents have upon students, particularly students who these documents unjustly label mentally ill and potentially violent. Intervening at a school district level is among the most effective options because school districts must revise and resubmit their mental health plans to the state each year. As Chapter 4 notes, MH plans are constructed and approved by school district personnel and are open to public debate, making MH plans easier to change than legislation. While MH plans are written in accordance with state-level regulations and best practices, school districts can include information that lessens the risk of marginalizing the students they govern. For example, Chapter 4 presents a sample of Pinellas County school district's MH plan that states that a student is considered a threat when that student is actively engaged in planning an attack on the school. Using this language to describe the type of students that personnel are seeking to identify in threat assessment practices avoids discussions of MH, thus mitigating that particular dominant narrative. According to local news sources, Pinellas County School District also deserves recognition for lessening students' exposure to law enforcement personnel who may view students as threats, because the school district mandates that only a counselor can refer a child for MH examination. While I was not able to corroborate

this information based on Pinellas County's MH plan, these two examples provide effective ways to mitigate some of the chief concerns laid out in this dissertation.

While school districts' MH plans must respond to state-level requirements, and most draw from state-sponsored best practices detailed in Chapter 4, authors can resist the dominant narratives of state-level MH legislation by providing ideological statements about the school district's treatment of students with MH concerns. Authors can state that the school district believes (supported by copious evidence) that most individuals with MH concerns are not violent. As we saw in the previous paragraph, statements about the type of students the school district proposes to identify as threats can drive the policies and protocols set forth by the plan. So too, authors of MH plans can resist identification and surveillance of students with MH concerns. School districts can state that mental illness diagnosis rests upon many factors and that decisions about diagnosis should be made in concert with the student, their guardian, and an MH care provider. School districts can remove language from MH plans that imply that guardians must share students' MH diagnoses and medical records with the school district, given that these details have been used to justify students' surveillance and discipline by school district personnel. Moreover, given the usage of these details in a statewide data repository, school districts can practice data resistance by requesting as few private details about students as possible. School districts can also recognize that surveillance and other disciplinary measures are unjustly enacted against students who lack privilege and implement statements against this unfair treatment.

Further Research

Further research can expand this dissertation's findings by addressing the project's limitations. This dissertation conducted a text analysis of public documents. However, sometimes texts are

not indicative of contexts. While coverage of MH policies and protocols in local newspapers suggests that these texts are promulgating stigma, further research should confirm these findings. Therefore, I propose fieldwork to determine how school districts deploy MH plans to respond to students with MH concerns. Doing this research will help me determine what types of MH concerns are most frequently responded to by school district personnel, as well has how often school district personnel use MH plans to guide their responses. Finally, completing this research would aid my determination of how I should intervene in the creation or revision of future MH plans. While I planned to do this research as a way of concluding my project, it was not safe to do this work during the COVID-19 pandemic.

To redress another of this project's limitations, I plan to expand the analysis beyond this project's case study by conducting a national-level study of MH legislation. In exploring the MH legislation of multiple states, I will be able to better understand how dominant narratives about mental illness and disability are furthered by their contexts. Widening the scope of this study would also improve my suggestions for constructing more useful MH policies and protocols within school districts because I would increase my exposure to the legislation, policies, protocols, and systems that regulate MH. After completing this additional analysis, I would be prepared to suggest interventions within MH policies at state levels, broadening the reach of my study.

Further research associated with this project will explore the MH education available within school districts at both state and national levels. Many MH plans referenced specific types of MH programs that will be introduced to students; SB 7026 requires that students receive MH education each year. Yet little is known about the curriculum of MH education programs. While SB 7026 implies that MH education should exist to connect individuals with MH treatment,

further research will test this implication. My purpose in this potential project will be to investigate these MH education programs to determine how such programs present mental illness, its identification, and treatment. Additionally, I will examine whether MH education perpetuates dominant narratives about MH. Further research will also examine the potential for TPC scholars to intervene by teaching students and other school district personnel to respond to MH concerns in equitable, harm-reducing ways.

Conclusion

When legislation presents individuals with mental illnesses as threats to public safety, policies and protocols mandated by that legislation become more likely to target students who are perceived to have MH concerns. Individuals with MH concerns already experience self-and-socially assigned stigma. Legislation, policies, and protocols that associate mental illness with the threat of violence compound that stigma through assignment of consequences that further mark these individuals as disabled or abnormal. By examining the ways that MH is constructed within legislative documents, I determine the material-discursive processes that transform students with MH concerns into threats. These processes contribute to the situated, contingent nature of medical uncertainty. Texts that ignore medical uncertainty's situational flux risk promoting dominant narratives about disability and mental illness. In this project, these dominant narratives result in increased stigma.

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