THE RIGHT TO HEALTH: A RHETORICAL ASSEMBLAGE OF MENTAL HEALTH ADVOCACY AND LEGISLATION

by

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To anyone who has struggled with a mental health condition: know that you are not alone.

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ABSTRACT

This dissertation examines the relationship between legislation and advocacy as forms of professional communication and interrogates their influence on mental health in the United States. Through a case study of one mental health nonprofit's advocacy materials and interactions with the legislative process, this dissertation demonstrates the entanglements between legislation and advocacy materials and how their circulation impacts mental health outcomes at the national, state, and local levels. I use two major research strategies to conduct my case study: 1) structured interviews with staff members from the nonprofit's national, Indiana state, and local offices and 2) a qualitative analysis of mental health legislation at the federal, state, and local levels, as well as the nonprofit's advocacy materials using Rhetorical Ecologies and Assemblage Theory as the primary theoretical frameworks. My findings suggest that, although both the organization and legislative bodies in the United States have some hierarchal tendencies, they function more like a rhizomatic, multilevel assemblage that is constantly evolving and growing as a result of the communicative interactions among its various components. This is due largely in part to the organization's grassroots structure, which enables staff and supporters from the state and local levels to affect change within and beyond the organization. Although components at the federal/national level have the most significant affects across the assemblage, my findings demonstrate how state and local components can disrupt or *deterritorialise* the assemblage to create new "lines of flight" or "flows" that expand the assemblage (DeLanda, 2006, 2016; Deleuze & Guattari, 1987; Fox & Alldred, 2015).

The findings and conclusions generated from this dissertation have several implications for mental health advocacy organizations, Technical and Professional Communication (TPC) pedagogy, and the Rhetoric of Health and Medicine (RHM) and the broader field of Rhetoric and Composition. For advocacy organizations, it provides a framework for tracking the potential material impacts of advocacy initiatives and legislation. For TPC pedagogy, it enables instructors to frame professional genres as components of a larger assemblage or organizational/institutional system, rather than as static artifacts. Finally, for RHM and Rhetoric and Composition, it provides a methodology for engaging in institutional and systems research that can be adapted to other rhetorical contexts.

CHAPTER 1: INTRODUCTION

1.1 Scope and Objective

The healthcare system in the United States is broken. Despite government attempts to make healthcare accessible and affordable through programs such as Medicare and Medicaid and legislative initiatives like the Affordable Care Act (ACA), 11.3% of Americans are either uninsured or continue to incur debt from medical bills—even with insurance (Auter, 2017). According to human resources consultant Aon Hewitt, individuals who have employer-provided health insurance have experienced a more than 50% increase in out-of-pocket spending on healthcare expenses since 2010, and a survey conducted by the Consumer Financial Protection Board found that individuals were most commonly contacted by debt collectors because of medical debt (Consumer Financial Protection Bureau, 2019; Olen, 2017). Even in the wake of the COVID-19 pandemic, the ACA's future remains uncertain, as the Trump Administration continues to implore the Supreme Court to strike down the law (Katkov, 2020). The Supreme Court is scheduled to hear arguments for *California v. Texas*, which essentially challenges the constitutionality of the law's individual mandate and could potentially invalidate the entire law (Musumeci, 2020; Schwartz, 2020). If this action occurs, millions of Americans could lose access to their health insurance.

The situation is especially dire for individuals living with a mental health condition. According to the National Institute of Mental Health (2019), 1 in 5 adults live with a mental illness. However, only about half of those individuals receive treatment because of financial constraints, mental health professional shortages, and the stigma surrounding mental illness (Health Resources and Services Administration, 2020; Kaiser Family Foundation, 2017). Partly to blame for these problems is the lack of government funding for mental health. Because of insufficient government interventions, the nonprofit sector has grown significantly and subsumed some of the aid and advocacy for mental health issues (NCCS Team, 2020; Salamon, 1994). These organizations provide essential services to the public while advocating for mental health initiatives at national, state, and local levels.

Legislation and advocacy are intertwined, as advocacy can lead to changes in legislative agendas, and nonprofits and other advocacy organizations often exist to fill in the ever-shifting

gaps created by legislation. Therefore, this dissertation examines the relationship between advocacy and legislation through a case study of one mental health nonprofit's interactions with the legislative process. While this study focuses on one organization and uses their advocacy materials (such as pamphlets, email blasts, blogs, letters, and speeches to Congress) as some of the primary artifacts of analysis, it moves beyond organizational boundaries to determine how those materials interact with mental health legislation. Furthermore, because the structure of the nonprofit in this study consists of three tiers or levels (national, state, and local), it will also examine how advocacy materials and legislation interact amongst these levels. To accomplish this task, this study uses Rhetorical Ecologies and Assemblage Theory as theoretical frameworks. Assemblage Theory asserts that any system (such as the mental health system in the United States) must be analyzed through the interactions among its individual components (DeLanda, 2006, 2016; Deleuze & Guattari, 1987) while Rhetorical Ecologies highlights the transformation of discourses and texts as they circulate through space and time (Edbauer, 2005). These frameworks supply the terminology used to describe the rhetorical trends and relationships across the texts and discourses examined in this dissertation.

1.2 About the Organization

The National Mental Health Organization (NMHO)[1] is a grassroots organization that promotes mental health awareness and provides outreach and support to those affected by mental illness. The NMHO promotes mental health in several key ways:

- Education: Local affiliates provide educational courses, presentations, and support groups to individuals living with a mental illness along with their family and friends. Some of these resources are also aimed at educating the community with presentations and workshops at schools or with law enforcement officials. A majority of volunteers who led courses/groups or give presentations are either in recovery from a mental health condition or have experienced mental illness in some other capacity, such as through a family or friend.
- Advocacy: NMHO at all levels helps to shape public policy in favor of improved mental health in the United States. Some of their efforts have included more funding for mental

[1] The National Mental Health Organization (NMHO) is a pseudonym used to maintain privacy for the organization and its staff members.

health research, better access to treatment and services, and mental health parity that ensures equal treatment to physical illness in health insurance plans.

- Awareness: NMHO hosts several events and activities aimed at fighting stigma and raising awareness for mental health, including a Mental Illness Awareness Week. They also communicate with reporters to make sure mental health issues are accurately represented in the media.

NMHO National serves as the headquarters for the entire organization, and they provide advocacy and support to their state-level organizations and local affiliates. NMHO Indiana, a state level organization, provides advocacy, support, education, and training within the state of Indiana and supports a network of over 20 local affiliates—one of which is a part of this case study (This local affiliate will be referred to as "NMHO Local" from here forward.). According to NMHO Indiana, about 1 in 17 Indiana residents are living with a serious mental illness but only about half of those diagnosed are receiving the treatment that they need. Furthermore, NMHO Indiana claims that more Indiana residents with mental illnesses are being treated in correctional facilities rather than in hospitals. NMHO Indiana, in partnership with NMHO Local and its other affiliates, aim to address these problems through a combination of local outreach and support and legislative advocacy. The NMHO staff and volunteers work with Indiana state legislators and facilitate educational programs and support groups that are catered to the local populations and community that they serve.

1.2.1 Why NMHO?

Healthcare in the United States is a complex network with laws, regulations, and protocols at national, state, and local levels. It is difficult to discuss health legislation and advocacy without considering each of these levels and how they interact since advocacy initiatives—no matter if they're coordinated locally or nationally—will be affected by national, state, and local issues. Since NMHO interacts with policy and legislation at all levels, I was able to see how their advocacy materials operate at the national, state, and local levels. Furthermore, since NMHO works with legislators, mental health professionals, and individuals in the communities that they serve, I was able to study the different rhetorical aspects of their advocacy work.

Additionally, mental health is often an overlooked component of healthcare. Although mental health parity laws dictate that mental health must be treated equally to other types of healthcare covered by insurance, many people living in the United States do not receive adequate care, and their access to mental health services is even more limited. According to Varrell (2017), over 55% of U.S. counties do not have psychiatrists, and areas that do have mental health professionals simply do not have enough providers to support the local populations. Therefore, another reason I chose the NMHO was because a major component of advocacy work is calling attention to important issues that have been neglected or ill-handled in the past, and the NMHO has been successful at helping to bring mental health to the forefront of healthcare policy.

I also chose to work with mental health, advocacy, and legislation because of my own experiences with mental illness and navigating the complexities of the American healthcare system. I have struggled with anxiety for most of my life, and several years ago I began seeking treatment for generalized anxiety and social anxiety. I first reached out to my institution's counseling services, but, because of staffing issues, my case was not deemed severe enough to qualify for individual counseling. Fortunately, my insurance does cover off-campus counseling services, so I found an off-campus therapist and began seeing her 2-3 times a month. However, although she was kind and understanding, she and I did not connect, and after almost a year of appointments, I did not experience much progress. Each session cost about $15 with my insurance, and while this was not an immense expense, it did add up over time, and it did not make sense to continue paying for a treatment that wasn't working. Therefore, I decided to leave therapy and, unfortunately, I have not been back since. The county where I live is designated as a Health Professional Shortage Area (HPSA) for mental health care (Health Resources and Services Administration, 2020). This means that there are not enough mental health professionals to adequately serve the number of people who live in the area. Because of this shortage, I have had difficulty finding a therapist who, in addition to accepting my insurance, has open appointments. The cause of this shortage is more or less due to a lack of funding and resources for mental health at both the state and national level. Advocacy initiatives that aim to encourage reforms in mental health legislation personally affect my own wellbeing, as well as the wellbeing of other individuals who find themselves in a similar predicament. Therefore, this dissertation, and my partnership with the NMHO, is very much entangled within my own personal journey in addition to my professional endeavors. I disclose this aspect of my identity to acknowledge my

subjective stance as a researcher. However, I also believe that my personal experiences are an asset because I have firsthand knowledge of how texts like legislation, that seem so distant from everyday life because of their technical "legalese" language, directly impact individuals' health and wellbeing.

In the subsequent sections, I first provide a history of healthcare legislation and advocacy in the United States. Then, I identify the current gaps in mental health legislation and advocacy research that this dissertation aims to address. Finally, I present this study's research questions and provide an overview of each chapter.

1.3 History of Healthcare Legislation and Advocacy in the United States

Mental health advocacy in the United States is intertwined with public policy and legislation, both which have rich, complex histories. In order to understand mental health advocacy, it's important to look back at how the current state of healthcare developed through government intervention.

1.3.1 History of Healthcare Legislation

Government involvement in healthcare in the United States can be traced back to 1798 with The Act for the Relief of Sick and Disabled Seamen, which funded hospitals and medical care for sailors who became ill or disabled on the job (Associated Press, 2010). However, serious conversations surrounding health insurance and healthcare reform did not emerge until Theodore Roosevelt's presidency (1901-1909). Roosevelt supported a government-based health insurance system, but most conversations surrounding reform took place beyond governmental institutions (Palmer, 1999). In 1912, the National Convention of Insurance Commissioners developed the first model of legislation meant to regulate health insurance. Then, in 1915, the American Association for Labor Legislation (AALL) drafted a bill that would require individuals to obtain health insurance; however, because of World War I and minimal state interest, it failed to gain traction (Kaiser Family Foundation, 2011). This inaction led to several reform efforts, resulting in the passage of the Snyder Act of 1920, which provided healthcare for Native Americans and was the precursor to the Indian Health Service; the Sheppard-Towner Act in 1921, which provided funds to states that created prenatal and child health centers; and The Veterans Act of

1924, which provided health care to veterans injured in the line of duty (Associated Press, 2010; Kaiser Family Foundation, 2011).

Franklin Delano Roosevelt attempted to pass national health insurance several times during the Depression and World War II. His first attempt was in 1935 through the Social Security Act, but health reform failed to make it into the legislation, and all the Act included was grants that restored many of the programs for maternal and children's health that had been established through the Sheppard-Towner Act. In 1943, Roosevelt once again introduced legislation that would provide universal healthcare through social security, which was meant to "move toward a system of 'cradle to grave' social insurance," but this effort failed as well (Kaiser Family Foundation, 2011, p. 4). Harry Truman then attempted to resume the cause for national healthcare between 1945 and 1949, but concerns about socialism, southern Democrats who feared it would cause desegregation, and the disapproval of the American Medical Association caused his proposals to fail. It wasn't until 1965, when President Lyndon B. Johnson approved Medicare and Medicaid through the Social Security Act, that there was any legislation to provide insurance to the retired and individuals with disabilities who could not afford or obtain private plans or employer-based health coverage. The final push for national health care during this era came from proposals written by Senator Ted Kennedy in the 1970s, but his efforts failed due to the economic recession (Kaiser Foundation, 2011).

Another concerted effort to reform healthcare did not occur again until the Clinton Administration, when he proposed the Health Security Act, which was a "managed competition approach" that required "universal coverage, employer and individual mandates, competition between insurers, and government regulation to control costs" (Kaiser Foundation, 2011, p. 12). However, this act never progressed in Congress due to opposition from the Health Insurance Association of America and the National Federation of Independent Businesses, as they believed the legislation would place undue strain on small businesses. Additionally, other alternatives, such as "the McDermott/Wellstone single payer health insurance proposal and Cooper's proposal for managed competition without a guarantee of universal coverage" were all presented at the same time, thereby splintering support and defeating any comprehensive reform (Kaiser Foundation, 2011, p. 13). However, in 1996 and 1997, respectively, the Health Insurance Portability and Accountability Act (HIPAA) and the State Children's Health Insurance Program (S-CHIP), which was championed by former First Lady Hilary Clinton, were enacted. HIPAA

"restricts the use of pre-existing conditions in health coverage determinations, sets standards for medical records privacy, and establishes tax-favored treatment of long-term care insurance," while S-CHIP, as a part of the Balanced Budget Act, "provides block grants to states allowing for coverage of low-income children above Medicaid eligibility levels" (Kaiser Foundation, 2011, p. 14).

While these two pieces of legislation are indeed significant and helped to improve access to healthcare, it would take another 13 years for comprehensive reform with President Obama's Patient Protection and Affordable Care Act (ACA) of 2010. The ACA eliminates pre-existing conditions and requires insurance plans to cover people no matter their health status (i.e., insurance companies cannot deny someone because of a pre-existing condition), as well as provide free preventative care. Additionally, it ends lifetime and yearly limits on coverage of essential health benefits ("Health insurance rights & protections," n.d.). One major component of the ACA is the health insurance marketplace. Individuals who have lost their health insurance or who do not already have insurance through their employers can browse and purchase plans on the marketplace. Additionally, the marketplace allows users to upload tax and employment/income information to see if they qualify for reduced premiums or other out-of-pocket costs associated with healthcare (Internal Revenue Service, 2020). According to the Kaiser Family Foundation, the number of uninsured individuals decreased considerably after the ACA took effect. The number of insured individuals in 2010—the year the ACA was passed—was 46.5 million. In 2016, that number fell to approximately 27 million (Tolbert et al., 2019).

However, despite these improvements, the ACA has been controversial since it was first proposed in Congress in 2009. Conservative lawmakers opposed the law's individual mandate, which imposes a penalty on anyone who does not purchase healthcare through an employer or the health insurance marketplace. Senate Republicans filibustered the bill with the intent to kill it, but they ultimately only delayed its passage. In 2017, when the Republicans had a majority in both the House and Senate, they attempted to pass the American Health Care Act (AHCA). This bill would have partially repealed the ACA by removing the individual mandate as well as the employer mandate, which required all businesses with over 50 employees to provide health insurance to all who were full-time. It also would have rolled back Medicaid expansion in addition to weakening rules related to pre-existing conditions and essential health benefits. However, while the House passed the bill, it died in the Senate due to withdrawn support from

several key Republican figures (Norris, 2020). Therefore, to this day, the ACA remains the supreme piece of healthcare legislation in the United States, although, as stated previously, it's still not safe.

1.3.2 History of Mental Health Policy and Legislation

Mental health policy and legislation has its own fraught history entangled within broader health policy initiatives. Before the 1950s, people with mental illnesses were either relegated to public mental hospitals where they were subjected to neglect and painful therapies, or they were forced to live in squalid conditions on the streets or in slums. Even treatments for less severe mental illnesses, or for those who were wealthy and could afford treatment from private hospitals or private practices, were either nonexistent or ineffective. In the 19th century and the first half of the 20th century, states had centralized mental health institutions, and all the funding from the states would go straight to those institutions (Frank & Glied, 2006).

Prior to the 1960s, mental health policy was primarily dictated by state mental health directors and public mental hospitals run by psychiatrists. Some states (the first being New York, California, and Massachusetts) began developing community-based mental health clinics with outpatient facilities that were less expensive than state mental hospitals. These same state officials also championed initiatives at the national level, including the founding of the National Institute of Mental Health (NIMH) in the late 1940s and the Joint Commission on Mental Illness and Health (JCMIH) in the 1950s, which included private interest groups and advocacy organizations. The JCMIH's mission was to improve conditions in public mental hospitals and to develop more community-based care facilities that treated people with severe mental illness. The federal government became interested in these community initiatives and began "forming federal-local partnerships based on financing arrangements that mimicked the [1946] Hill-Burton hospital expansion program," which increased the number of people local hospitals could serve (Frank & Glied, 2006, p. 93).

However, it wasn't until Medicaid, Medicare, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) that the federal government provided more significant funding and regulation to mental health. Medicaid and Medicare reduced the cost of mental health care to the states and allowed those with a low-income or disability access to mental health services from a variety of practitioners, including psychiatric units, community

mental health centers, outpatient mental health clinics, and some private practice psychiatrists and psychologists. However, mental hospitals could not receive Medicaid payments under the Institution of Mental Disease (IMD) exclusion, which led to more funding and care in nursing homes, general hospitals, and community mental health centers. That funding now primarily comes through block grants to states, which are administered by the Substances Abuse and Mental Health Services Administration (SAMHSA). Funding from these grants has gradually declined, which, in turn, has led to the weakening influence of mental health policy makers. Mental health agencies have more significant involvement in SAMHSA than in other areas of federal government, like the Social Security Administration (SSA), the Centers for Medicaid and Medicare Services (CMS), and the Department of Housing and Urban Development (HUD), all which now primarily create policy and provide much more significant funding for mental health care (Frank & Glied, 2006).

Community mental health centers in particular have become a primary focus at the federal level. In 1963, President John F. Kennedy signed the Community Mental Health Act (CMHA), which provided grants to build local mental health centers as alternatives to state mental institutions (SAMHSA, 2016). Then, President Jimmy Carter signed the Mental Health Systems Act of 1980 (MHSA), which funded community health centers across the United States. However, shortly after taking office, the Reagan Administration repealed almost the entirety of the legislation with the Omnibus Budget Reconciliation Act of 1981, which created single mental health block grants for each state with funding that could be used at the state's discretion (NIH Almanac, 2017). Thus, the entire American mental health system gradually became less decentralized and turned into "an array of largely uncoordinated programs and resources" that receive funding from a number of different federal, state, and private organizations (Frank & Glied, 2006, p. 5).

Following the Reagan Administration, the 1990s saw several pieces of significant mental health legislation: first, the Americans with Disabilities Act, which requires employers to make reasonable accommodations for individuals with disabilities, including those with mental health conditions (Frank & Glied, 2006); then, the Mental Health Parity Act of 1996 (MHPA), which mandated that "large group health plans cannot impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits" (Center for Consumer Information & Insurance Oversight, n.d.). However, it wasn't until 2008,

with the passage of the Mental Health Parity and Addiction Act (MHPAEA), that these protections extended to all insurers that offer mental health benefits and also included substance abuse disorders as well as ended lifetime and annual limits for mental illnesses (Lustig, 2012, p. 52). The ACA then further protected mental health coverage by defining mental health and substance use disorder services as "essential health benefits" that all providers must cover ("Health benefits & coverage," n.d.). Since the ACA, the most significant piece of mental health legislation has been the Helping Families in Mental Health Crisis Reform Act of 2016. As a part of the 21st Century Cures Act, this law further strengthens mental health parity through stricter enforcement measures as well as bolsters evidence-based treatments, advance screening, and early intervention through research management and funding (Levin, 2016; Mental Health America, 2016).

The judicial branch has also played an integral role in mental health across the country. Several court cases, including *Baxstrom V. Herald*, *Lessard V. Schmidt*, and *Vitek v. Jones* established civil rights for people with severe mental illnesses, including limits on involuntary commitment. Other cases, such as *Mills v. Rogers*, concluded that simply having a mental illness doesn't automatically preclude an individual from giving informed consent, which meant that medication could no longer be administered without a patient's consent (Frank & Glied, 2006). Then, *Wyatt V. Stickney*, perhaps one of the most influential mental health legal cases, established standards of care for mental health treatment with a class-action lawsuit against Bryce Hospital, Searcy Hospital, and Camp Partlow in Alabama due to their substandard conditions and medically unnecessary treatments given to patients (Belcher, 2016). These lawsuits also led to the Civil Rights of Institutionalized Persons Act (CRIPA), which enables the Department of Justice to investigate cases of abuse or neglect in public mental facilities. Finally, *Olmstead v. L.C. and E.W.* ruled that it is a violation of the Americans with Disabilities Act to keep individuals with disabilities in institutions rather finding an alternative community placement such as a nursing home, and *Miller v. Alabama* ruled that mandatory life without parole sentences for minors is unconstitutional, in part because of the effects on juvenile's mental health (Equal Justice Initiative, 2013; Frank & Glied, 2006).

1.3.3 Mental Health Advocacy

Behind these pieces of policy and legislation were not only government officials but also special interest groups, activists, and nonprofit organizations who lobby and advocate for improved mental health outcomes. In the field of medicine, healthcare advocacy is defined as "activities related to ensuring access to care, navigating the system, mobilizing resources, addressing health inequities, influencing health policy and creating system change" (Hubinette et al., 2016, p. 128). Mental health advocacy specifically involves reducing stigma and discrimination against individuals living with a mental illness and includes "various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes" (World Health Organization, 2003, p. 2). Mental health advocacy in the United States began through various grassroots movements with family members of people with mental illnesses and individuals with mental illnesses themselves coming together and forming coalitions to raise awareness and improve mental health conditions. Some of these coalitions formed into well-established organizations that eventually gained support from mental health professionals and government institutions.

Perhaps two of the oldest and most well-established of these organizations are Mental Health America (MHA) and the National Alliance on Mental Illness (NAMI). MHA was founded in 1909 by Clifford W. Beers, who had firsthand experience with bipolar disorder, along with psychiatrist Adolf Meyer. The organization's goals, which have remained constant, include "improving attitudes toward mental illness" and those living with mental illness, "improving services for people with mental illness," and "working for the prevention of mental illnesses and the promotion of mental health" (Mental Health America, n.d.b). The organization has been integral to passing mental health reform legislation since its inception. NAMI is a grassroots organization that promotes mental health awareness and provides outreach and support to those affected by mental illness. NAMI was officially founded in 1979 but first emerged in 1977 when mothers Harriet Shetler and Beverly Young, whose sons both had schizophrenia, met to discuss the challenges of raising a child with a mental illness when services and treatment were limited and mental health was stigmatized (NAMI Wisconsin, n.d.). These organizations have raised awareness and fought for issues such as the lack of mental health services in many communities, the unaffordable cost of mental health care and lack of parity between mental and physical

health, low quality care in mental health and psychiatric facilities, and stigma and lack of support for individuals living with mental illness (World Health Organization, 2003, p. 2).

The term "healthcare advocacy" is often conflated with "medical health promotion," which "involves efforts to prevent or reduce disease by relying on change in an individual's behavior" (e.g., adjusting dietary and exercise habits, quitting smoking, etc.) (Hubinette et al, 2016, p. 129). As Hubinette et al. (2016) point out, when medical professionals confine healthcare advocacy to individual patient intervention, they overlook the broader systems at play in the health inequities that many citizens in the United States face. Included in those systems are legislation and politics. In *Public Health Policy: Issues, Theories, and Advocacy*, Bhattacharya (2013) describes how laws and political agendas affect health initiatives. To assess how laws affect healthcare, Bhattacharya cites Gostin's (2008) definition of public health law:

> the study of the legal powers and duties of the state, in collaboration with its partners (e.g. healthcare, business, the community, the media, and academe), to ensure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population), and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally proprietary, and other legally protected interests of individuals. (p. 5)

Essentially, governing bodies that produce legislation must strike a balance between providing certain services and benefits to citizens and protecting their individual freedoms from unnecessary interference in personal health decisions.

These decisions stem from four different levels of legislation: federal and state constitutions, statues, regulations, and common law. Federal and state constitutions will dictate the statutes that get passed by legislative bodies. Regulations—issued by governmental agencies rather than legislative bodies—"translate … statutes' broadly worded mandates into specific rules for implementation"; they "provide the details necessary to put a statute into practice" (Bhattacharya, 2013, p. 9). So, for example, the ACA is a federal statute that provides broad guidelines about healthcare in the United States, and regulations created by agencies such as the Food and Drug Administration and the Centers for Disease Control and Prevention are based on language in the ACA. Common law, on the other hand, is "a dynamic process of interpretation" where courts examine "existing statutes and regulations and also prior court rulings to ascertain the current state of the law as it should be applied to an issue at hand" (Bhattacharya, 2013, p. 10). In other words, common law functions on a case-by-case basis to determine how statutes and regulations affect individual healthcare issues. Often, these cases stem from issues with

"state police powers" where state-level statutes and regulations may interfere or conflict with the federal constitution (Bhattacharya, 2013, p. 23).

As Bhattacharya (2013) points out, in addition to following existing legislation, healthcare advocates must pay attention to the political process, as healthcare issues "are shaped by different persons and parties over time" and politicians will often "politick" using health issues; that is, they will use healthcare to promote their own political agenda and gain power and influence (p. 107-108). Therefore, he argues that it is important for healthcare advocates to know the political history behind the governing individuals and parties in order to create an impactful strategy that either furthers a partisan agenda that may be in their favor or, if possible, gain bipartisan support (Bhattacharya, 2013).

According to Lustig (2012), one way to successfully lobby for healthcare policies is through collaboration among professionals and mental health organizations because it heightens the persuasiveness of the message. A professional or group of professionals addressing the legislature alone leaves the impression that their concern is a "guild issue" and that they are acting in the interest of self-gain. However, as Lustig (2012) states, when health professionals collaborate with nonprofit or nongovernmental organizations, along with individuals and family members affected by an illness, they are able to showcase multiple perspectives about their cause, including individual's and family's personal experiences with that illness and what is "clinically necessary" to improve health outcomes (p. 52). In fact, mental health organizations often have "advocacy days" where teams of mental health professionals, advocates, volunteers, and individuals living with mental illnesses will visit federal or state legislators and legislative aides to discuss important issues and how officials can use their legislation to better the lives of those with mental illnesses. Over the years, these organizations have championed issues such as the integration of mental health with other types of health care, mental health parity, and funding for biomedical research (Frank & Glied, 2006).

This collaborative advocacy produces direct benefits to people with mental illnesses and their families because it helps to reduce stigma, and it has also led to new mental health policies and legislation and improvements in mental health services. Because healthcare advocacy operates within complex legislative and political systems, it is imperative to study the laws that govern healthcare advocacy organizations and their relationship to politics in addition to their advocacy initiatives that support their targeted communities and populations.

1.4 Mental Health Legislation and Advocacy and Gaps in Current Research

This dissertation is situated in the Rhetoric of Health and Medicine (RHM)—in particular, the Rhetoric of Mental Health. RHM provides exigencies and frameworks to demonstrate how policy/legislation and mental health advocacy organizations together, as an assemblage, impact mental health outcomes. The entangled, rhetorical relationships between advocacy and legislation is a topic that is currently underexplored. Current research on advocacy and legislation, instead, addresses the two separately. Advocacy research, for example, focuses primarily on the effects of social media, particularly in terms organizational infrastructure (Velut, 2013) and stakeholder outreach (Guo & Saxton, 2014; Obar et al., 2012). Additionally, although RHM has addressed legislation (Jack, 2010; Jack & Applebaum, 2010; Markel, 2010; Racine et al., 2005; Segal, 2005b; Smith, 2000) and advocacy (Johnson, 2010; Molloy, 2015; Saunders, 2018; Uthappa, 2017), scholarship on the relationship between the two is limited, especially in terms of mental health. Therefore, this dissertation aims to address this gap in research by illustrating the reciprocal relationship between advocacy materials and legislation.

Reynolds (2018) describes the Rhetoric of Mental Health as a "smorgasbordy" body of work, as it dwells within a number of interdisciplinary spaces. However, no matter the context, researchers (Berkenkotter, 2001, 2008; Emmons & Emmons, 2010; Holladay, 2017; McCarthy & Gerring, 1994; Price & Siebers, 2011; Pryal, 2011) continually examine the *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM*)—the standard authority in mental health practice. Because of its command over the field of psychiatry, McCarthy (1991) characterized the *DSM* as a "charter document," which "establishes an organizing framework that specifies what is significant and draws people's attention to certain rules and relationships" (p. 359). Similarly, Berkenkotter (2001) defines it as a "meta-genre": "a mediational means or tool for stabilizing practices, such as conducting research …, diagnosing conditions, prescribing medication, writing treatment plans, and so forth" (p. 339). In other words, it standardizes the field of mental health and generates writing and discourse. Since the *DSM* has justifiably been a primary focus of Mental Health Rhetoric Research (MHRR), the field has devoted less attention to other texts and discourses that impact mental health outcomes. Therefore, this dissertation brings in another set of "charter documents" or "meta-genres" within the mental health rhetoric paradigm—legislation—and demonstrates how advocacy shapes those documents. Mental health advocacy and legislation have rich, complex histories that can illuminate current issues

surrounding mental health in the United States, so it is imperative to consider their impact on mental health in addition to foundational medical texts like the *DSM*.

Furthermore, RHM scholars have called for research that presents a more complex view of the increasingly distributed communication practices in medicine and health (Jensen, 2015; Keranen, 2014; Segal, 2009). This dissertation responds to this exigence by using Rhetorical Ecologies and Assemblage Theory to examine how a nonprofit's advocacy materials not only circulate throughout the public but also internally. This component of the study is particularly important because the organization operates at the national, state, and local levels—with offices dispersed throughout the country. This means that, depending on the level of the organization, their advocacy initiatives may be more focused on legislation in specific states or communities.

1.5 Research Questions and Thesis

To build on current research and address gaps in the literature, my dissertation answers the following questions:

- How do the different levels of mental health legislation and the different levels of a mental health advocacy organization interact and influence each other?
- How does federal, state, and local legislation impact the advocacy materials produced by mental health advocacy organizations?
- How do advocacy materials produced by mental health advocacy organizations attempt to impact federal, state, and local legislation?
- How do advocacy materials and legislation impact the United States mental health system at the federal, state, and local levels?

In short, the thesis of this dissertation is that legislation and advocacy materials at all three levels function as a complex, entangled assemblage, with each component involved producing flows or "lines of flight" that either attempt to stabilize/standardize (*territorialise*[2]) or destabilize/disrupt (*deterritorialise*) the assemblage as a whole (Deleuze & Guattari, 1987). However, my findings suggest that certain components of the assemblage, particularly those at

[2] This spelling is most commonly used in translations from the original French and in the secondary sources that cite Deleuze & Guattari's *A Thousand Plateaus*.

the federal/national level, have more power and influence and, therefore, more significant effects than other components at key moments as the assemblage evolves and fluctuates over time.

Essentially, my study finds that—given their federal/national, state, and local structure—the NMHO and legislative bodies in the United States are in many ways function hierarchically, and, therefore, NMHO National advocacy materials and federal legislation exert significant power within and beyond the assemblage. However, because the NMHO is a grassroots organization, and because stakeholders at all three levels of the organization openly communicate, collaborate, and share ideas with each other, the state and local levels have the ability to affect change across the assemblage. In terms of state and local legislation, there is less communication among the different levels of legislative bodies, and because state/local governments' primary purpose is to govern within their own municipalities, there are less opportunities for state/local legislation to produce affects across the assemblage. However, as my findings will demonstrate, there are opportunities to subvert federal/national initiatives.

Furthermore, as NMHO advocacy materials and legislation at all three levels circulate and interact throughout and beyond the assemblage, they produce changes that affect individual components and the assemblage as a whole. Namely, the content covered in NMHO's advocacy materials and the overall advocacy strategy is often a response to current legislative initiatives and actions taken by legislative officials. Moreover, the NMHO is able to influence legislation by directly communicating with lawmakers and by persuading their supporters to contact legislators and voice support for initiatives. Finally, the NMHO advocacy materials and legislative documents don't just impact each other: their circulation leads to actions, such as distributing funding/resources or establishing new programs, that materially affect mental health outcomes in the United States.

1.6 Dissertation Outline

The remaining chapters will provide a more thorough overview of the current research and literature in RHM, an explanation of the study's theoretical frameworks, the methods used to conduct the case study, a presentation of the data analysis and results, a discussion of the results, and implications for RHM and Rhetoric and Composition as well as suggestions for future research.

Chapter 2: Background and Literature Review focuses on how this project, and mental health advocacy and legislation in general, fits into Rhetoric and Composition and the subfield of RHM. In particular, I highlight the relationship between rhetoric and Organizational/Institutional Theory, as the language and discourse that circulate throughout the advocacy-legislative assemblage is entangled within organizational and institutional logics and structures. Additionally, I call attention to RHM's focus on the *Diagnostic and Statistical Manual of Mental Disorders* (the DSM)—in particular McCarthy (1991, 1992, 1994) and Berkenkotter (2001) who characterize this pivotal text as a "charter document" or "meta-genre" within the field of mental health. In Chapter 5, I ultimately argue that mental health legislation serves a similar function, as it generates more discourse, such as through advocacy. In Chapter 2, I also provide an overview of current research on healthcare advocacy outside Rhetoric and Composition, which primarily focuses on advocacy in the digital sphere as well as the push and pull between centralization and decentralization within advocacy organizations. This chapter demonstrates how the appropriate next step in mental health legislation and mental health advocacy research is to examine how the interactions between the two impact mental health outcomes in the United States, which is the aim of this dissertation project.

Chapter 3: Theoretical Framework & Methods first demonstrates how my study uses Assemblage Theory as well as materialist understandings of rhetoric and language to frame how legislative documents and advocacy materials interact and circulate within the United States mental healthcare system. I begin by tracing the "material turn" in rhetorical studies starting with Burke's (1966, 1969) concepts of identification and terministic screens and ending with Edbauer's (2005) Rhetorical Ecologies and circulation. Then, I break down the key ideas and concepts associated with Assemblage Theory, focusing most heavily on "lines of flight" or "flows" and "territorialisation/deterritorialisation." Ultimately, I use Assemblage Theory—and these three concepts in particular—to analyze my data in Chapter 5: Discussion. Then, I present the steps I took to conduct this case study. I begin by describing my research site, the IRB approval process, and my role as a volunteer-researcher. Throughout this study, I not only collected documents and conducted interviews with individuals involved in the organization, I also volunteered my time as a newsletter editor for NMHO Local. Therefore, I describe the dynamics of that role and how it affects my stance as a researcher. Then, I introduce my interview participants and questions, as well as the documents in the dataset. All interview

participants are former or current staff members at all three levels of the NMHO, and the documents consist of federal, state, and local legislation, as well as advocacy materials created and distributed by either NMHO National, NMHO Indiana, or NMHO Local. Finally, I describe my process for coding and analyzing the documents and interview transcripts.

Chapter 4: Results presents the major findings from my document analysis and the coding of my interviews. Specifically, I argue that the documents/media and initiatives that seem to exert the most influence across the advocacy-legislative assemblage often shift, so it is difficult to pinpoint a central driving force. Therefore, although the national, state, and local setup of the NMHO and legislation may appear to be hierarchies, the findings of this study demonstrate that the relationships among them is much more complex. Each section in this chapter is organized as responses to my research questions. This chapter also includes several assemblage maps, which demonstrate the relationships and interactions among the stakeholders/components involved in this study.

Chapter 5: Discussion connects the findings from the document analysis and the interviews to my theoretical framework and demonstrates how the language used in the legislative and advocacy materials leads to material outcomes and also attempts to either territorialise or deterritorialise the mental health system in the United States. Building off of the findings in Chapter 4, this chapter demonstrates how it is much more accurate to theorize these levels of the NMHO and legislation as an assemblage rather than a hierarchy because the relationships among components are constantly shifting based on social and historical processes—and the components which exert the most influence will change over time. Additionally, I explain how the language and the rhetorical moves used within the legislative and advocacy documents can lead to material or physical effects or actions (or, conversely, inactions) that then have either positive or negative effects on mental health services and treatment in the United States.

I conclude with *Chapter 6: Conclusion*, which discusses how my findings impact RHM as well as the broader field of Rhetoric and Composition. Additionally, I examine the implications of my research on healthcare advocacy organizations and how these methods might be adapted to demonstrate advocacy initiatives' effects on mental health outcomes at national, state, and local levels. Lastly, I present avenues for future research in this area along with pedagogical implications.

1.7 Conclusion

Ultimately, my dissertation contributes one of the first pieces of scholarships in RHM that examines the entangled rhetorical effects of healthcare legislation and advocacy. My research adds to RHM by demonstrating how discourse circulates in institutional and organizational contexts related to mental health, as well as expanding on methodologies that utilize Assemblage Theory. In the next chapter, I further explore how my project builds on past research both within and outside RHM.

CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

2.1 Introduction

Mental health in the United States is impacted by a number of influences and stakeholders, including medical research, healthcare providers, patients and their families, professional and special interest groups, government officials and institutions, and advocacy initiatives. This dissertation focuses on the latter two through the relationship between policy/legislation and mental health advocacy organizations. The relationship between public policy/legislation and advocacy is symbiotic, as advocacy can lead to changes in public policy or legislation, and nonprofits and other types of advocacy organizations often exist to fill in the ever-shifting gaps created by public policy and legislation. The nonprofit sector has, in large part, subsumed aid and advocacy initiatives for a number of issues within the United States, including mental health. Furthermore, the nonprofit sector as a whole has been steadily rising since the 1960s (Salamon, 1994). According to the National Center for Charitable Statistics, the number of nonprofit organizations in the United States as of 2013 reached over 1.5 million. Additionally, per the U.S. Department of Labor's Bureau of Labor Statistics, nonprofit employment has increased by over 17% between 2007 and 2016, in comparison to a less than 5% growth in the for-profit sector. Salamon (1994) attributes this expansion, in part, to legislative policies that have reduced social welfare spending and instead promoted intervention from organizations outside the government. These organizations have not only provided services to the public but have also advocated for particular causes—such as mental health—and, in turn, influenced legislation at national, state, and local levels.

Research that addresses mental health advocacy and legislation/policy spans across disciplines, including medicine, law, political science, business/marketing, sociology, and communication. Mental health advocacy and legislation/policy has also been addressed in Rhetoric and Composition, specifically in Technical and Professional Communication (TPC) and in the Rhetoric of Health and Medicine (RHM). However, RHM has not yet produced scholarship that examines the entangled rhetorical relationship between advocacy and legislation/policy. Therefore, I begin this chapter with an overview of current advocacy research outside Rhetoric and Composition. Then, since my research involves two different types of

institutions/organizations (nonprofits and legislative bodies), I address Institutional and Organizational Theory as it pertains to rhetoric, language, and communication. Finally, I provide an historical analysis of RHM and Mental Health Rhetoric Research (MHRR) and identify gaps that provide exigencies for this study. This review of literature ultimately reveals that the next step in researching mental health legislation and mental health advocacy should be to demonstrate how the two work together to affect mental health outcomes in the United States.

2.2 Current Advocacy Research Outside the Rhetoric and Composition

Much of the current research on healthcare advocacy deals with the changing landscape of the profession as new technologies enter the picture and affect how organizations function. At its core, advocacy work is highly distributed because it involves a variety of activities and strategies, including "lobbying, direct organizing, public education, policy advocacy, coalition building, and many others" and working with a number of stakeholders, such as legislators, community members, and partner organizations (Brady et al., 2015, p. 259).

More recently, the emergence of digital technologies has added another layer of complexity in terms of how advocacy organizations perform these activities and interact with their stakeholders. Several studies demonstrate how advocacy organizations have harnessed social media to communicate and perform outreach. For instance, Obar et al. (2012) surveyed advocacy groups in the United States to find out how they use social media for civic engagement and collective action. The groups that participated said that they used social media almost every day to communicate with the individuals they serve, and, overall, they believed that social media helped them to better accomplish their advocacy and organizational goals. Similarly, Guo & Saxton (2014), through their analysis of 188 civil rights and advocacy organizations, found that advocacy groups use Twitter for public education, awareness, coalition building, and calls to action. Additionally, organizations use the internet and social media to build and mobilize their communities, "as individuals who are separated by geographic and even socio/political boundaries can come together in digital spaces" and participate in actions such as signing online petitions or organizing rallies and protests (Brady et al., 2015, p. 260).

This wide adoption of social media and internet communication practices has prompted infrastructural changes to advocacy organizations. For example, Velut (2013) illustrates how digital technologies have enabled new strategies for mobilizing, which, in turn, has altered the

structures of activist organizations. In particular, he argues that these technologies "have not only consolidated ties between different activist subgroups, but also blurred boundaries between local, regional, national, and transnational spaces through a process … described as 'glocalization,'" meaning that organizations at different levels can establish a "system of political alliances with other local, national, or international partners for form cross-sectoral coalitions" (Velut, 2013, p. 188). Because of advocacy organizations' ability to use internet technologies to forge connections, Velut (2013) identifies a paradoxical effect where organizations' communications seem to be both more decentralized and centralized: "As new information technologies provide new opportunities to participate in the policy process," he says, "they compel advocacy networks to adopt a more horizontal decision-making process … [which] can rejuvenate grassroots activism and bolster—or restore—the democratic credentials of any advocacy network" (p. 188). Yet, at the same time, "internet technologies can also help to coordinate and centralize information … [and] can perpetuate vertical structures by facilitating coordination and centralization" (pp. 195-196). As a result, local organizations are often dependent on larger state or national organizations for support and resources or for lobbying work that helps them accomplish their initiatives and serve their community. However, these organizations also require the support of grassroots initiatives that can often lead to infrastructural changes at the national and state levels.

Therefore, advocacy organizations with this type of structure cannot be theorized or studied as top-down hierarchal organizations (even if some aspects of the organization may exhibit hierarchal qualities). Rather, they must be viewed as a number of distributed components interacting to drive their goals and initiatives. Furthermore, they are constantly interacting with other organizations and institutions, such as governmental bodies, and those interactions affect the impact that they make on their chosen causes. In the following section, I further explore the structure and innerworkings of institutions and organizations, particularly in terms of how they use and are shaped by rhetoric, language, and communication.

2.3 Rhetoric and Institutional/Organizational Theory

The concepts "institution" and "organization" often get used interchangeably. However, while they are related, institutions and organizations are different both in terms of purpose and scope. According to Institutional Economics scholar Geoffrey Hodgson (2006), institutions are

"systems of established prevalent social rules that structure social interactions" (p. 2). Institutions are associated with order, regulation, and conventions, and they, at the same time, create stability and enact change (Baba et al., 2012). Institutions include things like language systems, economic systems, and legislative bodies. Organizations, on the other hand, are described by Selznik (1949) as both "a mechanism designed to accomplish a specific goal" and "an organic social system" that is influenced by the actions and values of its members as well as outside forces (as cited in Baba et al., 2012, p. 81). Organizations include entities such as nonprofits, companies, or colleges/universities.

Baba et al. (2012) emphasize that while institutions and organizations are not the same, larger, more established organizations often exhibit some of the same behaviors as institutions, meaning that they will simultaneously attempt to maintain order while affecting change both within and outside the organization. Therefore, what is called "New Institutional Theory" is often used to analyze the behaviors and structures of individual organizations as well as the interactions amongst organizations and outside influences, like legislative bodies and society in general. "Actors" are an important component of New Institutional Theory and include individuals, organizations, and societies or nation-states. Individuals have the ability to act and create change but often can't do it on their own and, therefore, form coalitions or organizations. Societies/nation-states are more regulatory actors who attempt to maintain order in some form, as they are meant to govern individuals and organizations. Interactions amongst actors are important because it is these interactions that produce change (Baba et al., 2012). Additionally, it is through institutional influences that organizations "develop a specific character structure and identity," and members of that organization become invested not only for practical purposes, like gainful employment, but also because they "become increasingly committed to its purposes, and the organization becomes more deeply embedded within their social networks" (Baba et al., 2012, p. 81).

Institutions and organizations—no matter what type—are emergent and follow certain logical structures, meaning that they are constantly in the process of coming into being as they interact with internal and external forces. Furthermore, the logic behind that process can be theorized through what are called institutional logics (Baba et al., 2012). Institutional logics are defined as "*bundled sets* or *ensembles* of higher order meanings, values, norms, and/or rules that frame how individuals make sense of the world around them and consequently know how to act"

(Cloutier & Langley, 2013, p. 361). In other words, institutional logics constitute identities and interpretations as well as enable or restrict language and action. According to Brown et al. (2012), institutional logics are "encoded in discourses, collections of interrelated texts that provide vocabularies, specify norms, establish meanings, and create relations of power/knowledge" (p. 299). Essentially, they are entangled and dispersed throughout the systems, both symbolic and material, that make up our everyday lives (Cloutier & Langley, 2013).

The emphasis on institutional *logics* (rather than *an* institutional *logic*) is important because rarely do organizations and other actors follow a single logic. Actors are complex and follow multiple institutional logics, and their level of complexity is dependent on how centralized or fragmented they are (Cloutier & Langley, 2013). For example, an organization with multiple branches or levels—like national, state, and local, for instance—might be much more complex than a small organization that only serves one local area because the larger organization would have to contend with institutional logics that transcend the macro, meso, and micro levels. In terms of nonprofits specifically, it's important to note that they do not all share the same organizational structure. For example, as Budrys (2012) notes, nonprofit organizations vary in size and scope, and their identities are often contingent on not only the service that they provide but also their reach and the populations that they serve. Some smaller nonprofits may only serve one particular community while larger ones operate at a national or international scale. These larger nonprofits often function using an umbrella structure, which means that one national or international organization presides over a number of smaller affiliates that often operate at the state or local level.

This is the structure that NMHO uses, as NMHO National is the umbrella organization for over a thousand state and local affiliates. According to Young (2001), nonprofit umbrella organizations "work in coordinated fashion to achieve common systemwide goals," which means that there is a more centralized structure to guide members across all levels (pp. 292-293). However, he also claims that they often function like polities and economies, which means that they rely on "consensus-building" and "reciprocity and exchange among its participants" (p. 292). For example, the national or international level of the organization may be responsible for creating programs and all marketing/advocacy/training materials that go along with them, while the state and local organizations are responsible for facilitating those programs. Also, because

the state and local members are the ones who are most often making connections with the individuals that the organization serves, they may provide feedback and therefore influence the entire organization's priorities. Thus, while in many ways these types of nonprofits exhibit a hierarchal structure with one overarching institutional logic, this type of exchange shows that some power may be dispersed throughout the organization, and the state/local levels may possess their own logics that have the potential to infiltrate the organization.

It is through these institutional logics that institutions and organizations establish their identity and seek legitimacy both from insiders and outsiders. According to Clegg et al. (2007), organizational identity "is best understood in terms of the relationship between temporal difference (i.e. the performance of a stable identity over time) and spatial difference (i.e. by locating organizational identity in relation to other firms, both similar and different)" (p. 496). In other words, organizational identity involves creating an ongoing narrative surrounding the organization, as well as demonstrating how they compare to other organizations. Furthermore, organizations rely on both external and internal legitimacy. External legitimacy comes from individuals and institutions outside of the organization (such as government bodies, for example) and internal legitimacy comes from individuals inside the organization, like employees or staff members. Organizations need both external approval and the acceptance of their members in order to survive, and it is the actions and interactions between actors both within and outside the organization that shape its identity (Brown & Toyoki, 2013). Because of these interactions, organizational identity is dynamic rather than static and often changes over time (Gioia et al., 2000).

Moreover, it is through rhetoric and communication that institutions and organizations build legitimacy and shape their identity. According to Alvesson (1993) and Berger & Luckmann (1966), rhetoric is at the center of every organization, and communication/language is what builds an institution or an organization. Alvesson (1993) calls organizations "systems of persuasion," where organizational actors use language to construct messages surrounding the organizations, as well as dictate organizational boundaries (p. 1001). According to Blaschke et al. (2012), individual acts of communication connect to form "collectively an organization as a network of communication episodes" (p. 881), as well as networks of individuals, networks of human and non-human actors, and networks of topics—or, in other words, the linguistic concepts that make up an organization and connect the individuals within it. Those communication

episodes occur at the micro level (i.e., individual people within an organization), the meso level (i.e., pieces of communication that reflect the views of the organization as an entity), and the macro level (i.e., institutional messages that impact organizations). The formation of these networks is "neither an exclusively bottom-up process nor does it take place in isolation; instead, all communication processes are embedded in a wider societal context from which they can draw on readily available templates of meaning" (Blaschke et al., 2012, p. 883). For example, most colleges/universities and nonprofit organizations have mission statements that are shaped by institutional norms and the needs of society. Those mission statements dictate the actions of the organization as a whole well as those of the individuals within the organization. Mission statements also promote the organization by sending a message to outsiders about their priorities and how they serve the community. An organization's message is important because it can help them to make connections and expand.

To understand how organizations communicate their message, we can look to Lammers (2011) who develops a theory surrounding institutional messages and how they affect organizations. According to Lammers (2011), institutional messages are the vessels of institutional logics as they are "collations of thoughts that are intentional, enduring, have a wide reach, and encumber organizational participants to engage in certain behaviors or to take performative responses" (p. 154). In other words, institutional messages impact the behaviors and attitudes of organizational actors. They are aimed both internally and externally and serve the purpose of promoting an organization or simply informing the public about something related to the organization. Lammers (2011) identifies four features that determine the "institutionality" of a message: establishment, reach, encumbency, and intentionality. The establishment is essentially the frequency and endurance of a message. The reach is the size and number of audiences who receive the message. Encumbency involves the duty that audiences have to comply with the message. An encumbent message is one that must be followed, while an unencumbent message is more like a suggestion. Finally, intentionality is whether or not the message takes on a life of its own beyond an individual or an organizational actor (Lammers, 2011, pp. 171-173). These features enable researchers to track the impact and influence of institutional messages, how they are spread both within and across organizations, and their ability to enact change.

Institutional change occurs when an institutional logic is undermined by a different logic, which then causes "deinstitutionalization." Deinstitutionalization is when an institutional practice or logic loses legitimacy or meaning (Brown et al., 2012). According to Dacin et al. (2002), deinstitutionalisation can occur because of functional issues (i.e. problems within the institution), political issues (i.e., a shift in power or a shift in priorities within political institutions), and social issues (i.e., a shift in the types of people within the institution, a shift in values, changes to laws, etc.). Deinstitutionalization or institutional change can start or take place at all different levels (micro, meso, and macro), and it can either occur gradually or abruptly. Organizations can put pressure on institutions to change, such as through lobbying and advocacy initiatives. These initiatives often involve a network of communicative processes that include things like conversations, press conferences, or testimony, as well as a variety of written documents.

For example, Brown et al. (2012) look at how one text written by the Australian Senate Committee created institutional changes. This text was a report on aged cared that argued that young people with a disability should be treated separately than those who are elderly with a disability. They looked at the rhetorical strategies used within the report and then also the outcomes after the report was published (i.e., the passage of new laws, etc.). In the end, the report resulted in young people with disabilities being moved to new centers separate from the elderly. They found that the language used in that report disavowed one logic ("dual care") by affirming another logic ("age-appropriate care"), as well as by discrediting other alternative logics ("disability appropriate" and "person-specific care") (Brown et al., 2012, p. 313). Furthermore, they found that, in addition to using statistics and data, the organization utilized individual's experiences to create an argument. They also acknowledged that the organization had institutional clout and power, which probably made a significant difference in their ability to create change with a single document. Because of their findings, Brown et al. (2012) suggest that there should be more research that addresses "the political role of texts" and "how they are embedded in and affect relations of power" (p. 315). This type of work is at the core of Rhetoric and Composition research, and RHM, as a field, provides exigencies and frameworks for this type of scholarship to show how policy/legislation and the materials produced by mental health advocacy organizations together impact mental health outcomes.

2.4 The Emergence of the Rhetoric of Health and Medicine

As Heifferon & Brown (2000) suggest, Plato uses the *Gorgias* to frame rhetoric (a form of flattery or a "knack") in opposition to medicine (an art or *techne*), so the emergence of RHM can be seen as "rectifying the historic split between science and rhetoric" (p. 246). Persuasion is indeed a "central element" in a number of medical and health contexts as doctors must get patients to follow medical advice, patients must sometimes convince doctors that something is (or isn't) wrong with them, public health officials must persuade the public to act on public health crises, etc. However, medicine and health are rhetorical not only because of persuasion but also because of how their "systems of norms and values operate discursively in doctor-patient interviews, in conversations in hospital corridors, in public debate on health policy, and in the apparatus of disease classification" (Segal, 2005a, p. 3). In other words, what we conceptualize as medicine or health is created through the language we use to describe and define it.

The roots of RHM can be traced back to the emergence of Writing Across the Curriculum (WAC) in the 1970s. WAC was originally a pedagogical movement with emphases on "writing to learn" and "learning to write" in disciplines across the university. However, it underlined rhetoric's "inherent interdisciplinary" nature, which, in turn, inspired rhetorical studies in the sciences and in the workplace in the 1980s, where RHM was born (Heifferon & Brown, 2000, 2008). Solomon (1985) and Anderson (1989) published some of the first rhetorical studies of medicine with Solomon (1985) rhetorically analyzing the language in medical reports from the Tuskegee Syphilis Project, and Anderson (1989) studying the writings of surgeon Richard Selzer. Then, in the 1990s, the health and medical fields "saw a return to the value of humanities and an understanding of the role of language in both medical school curricula and health practice," which provided an opening for rhetoricians to carve an identity within both the healthcare community and rhetorical studies (Heifferon & Brown, 2008, p. 3). Works such as Celeste Condit's (1990) *Decoding Abortion Rhetoric: Communicating Social Change* and *The Meanings of the Gene: Public Debates about Heredity* (1999) helped to establish a connection between health/medicine and rhetoric/discourse.

Throughout its history, RHM has been "theoretically and methodologically diverse" (Segal, 2009, p. 229), as well as "inter-, trans-, and postdisciplinary" (Segal, 2005b, p. 317) with its variety of methods, research sites, and research questions, many of which that, although

primarily focus on language and text, draw from fields such as anthropology, sociology, psychology, philosophy, history, communication, and political science (Angeli & Johnson-Sheehan, 2018; Barton, 2005; Segal, 2005b). Researchers across RHM's history have attempted to define and categorize the field. Segal (2005b) argues that much of the "rhetorical" research occurs outside of the discipline and gets published in disparate places, making it difficult to pinpoint and define the field. Nonetheless, Segal (2005a) seems to create her own categories when she says, "rhetoric is useful as a means of studying health and medicine as a discourse-in-use,...as a public discourse,...as a commercial discourse,...as a professional discourse,...[and] as a discourse of service" (pp. 154-155).

Reed (2018) builds on Segal's work through her own classification system using RHM special issues and journals that have published five or more RHM articles. She says that RHM scholarship could ostensibly be organized by "rhetorical topoi, medical topoi, sites of practice, and methods," but the research is too varied for these heuristics to be useful. For example, in the 54 articles that Reed (2018) analyzed, there were "22 unique medical topoi," 21 different rhetorical topoi, and sites of studies and methods varied significantly even in articles that shared the same general subject matter (p. 180). Therefore, she instead identified five areas of scholarship: the identity of RHM, disciplinarity, process, ecological interaction, and maneuverability. The identity of RHM, of course, refers to how scholars conceptualize the field, i.e., what counts as rhetorical scholarship? What are the methods we use? What are the topics we address? Then, disciplinarity focuses on the discourse associated with the medical and health fields, in particular examining professional documents and interrogating how medical knowledge gets created, as well as the types of knowledge and evidence that are seen as legitimate in medical and health fields. Similarly, process refers to how medical and health texts get written, or the practices of writers in the medical and health field, which include not only human processes but also technology's role in the creation of discourse. Ecological interaction, on the other hand, addresses how the discourse associated with medicine and health interacts with other discursive systems and "demonstrates how medicine establishes and operationalizes authority over bodies, or conversely, how its authority is called into question through contact with other discourses," such as advocacy or political rhetorics (Reed, 2018, p. 186). Likewise, maneuverability refers to "how … patients and other publics engage and resist medical rhetoric" in a way that ultimately alters medical and health practices in some form (Reed, 2018, p. 188).

Reed's categories illustrate both the diversity of topics covered in RHM as well as the connections that exist across journals and sub-disciplines within the field. We might say that this study falls under the "ecological interaction" category, since it explores mental health in terms of advocacy and legislation, both of which are discourses technically outside the fields of medicine and health.

2.5 Mental Health Rhetoric Research within the Rhetoric of Health and Medicine

Mental Health Rhetoric Research (MHRR) as a subfield of RHM is itself highly interdisciplinary and difficult to define. According to Reynolds (2018) the Rhetoric of Mental Health can be described as a "smorgasbordy" body of work because it inhabits a number of subdisciplines within Writing Studies, including Rhetoric and Composition, Technical and Professional Communication, Scientific/Medical Rhetoric, Genre Studies, Discourse Community Studies, Neurorhetorics, "Rhetorics of Atypicality," and "Rhetorics of Madness" (p. 3). Research on Mental Health Rhetorics dates back to the 1980s with earlier work focusing on mental health providers, while later work primarily addresses patients and their families (Reynolds & Mair, 1989; Reynolds et al., 1992, 1995).

Reynolds & Mair (1989) and Reynolds et al. (1992) brought the field some of the first MHRR scholarship with their work on communication between mental health practitioners via patient records. In particular, they looked at the challenges that mental health practitioners face and attempted to map the profession and provide suggestions for future MHRR research. Additionally, Reynolds et al. (1992) featured a "Foreword" and "Postscript" written by clinicians, which marked RHM's and MHRR's commitment to reach beyond the field and develop relationships with medical and health practitioners.

The *Diagnostic and Statistical Manual of Mental Disorders* (the *DSM*) is perhaps the most cited medical text by MHRR practitioners. The *DSM*, according to mental health care practitioners, is an authoritative medical text but is, on the other hand, "a house of cards from a rhetorician's point of view—a biased social construction fraught with validity and reliability issues" (Reynolds, 2018, p. 3). It was first published in 1952 by the American Psychiatric Association in response to WWII veterans needing psychiatric care. It has undergone four revisions since its initial publication: *DSM-II* (1968), *DSM-III* (1980), *DSM-IV* (1994), and *DSM-V* (2013). Across the five versions, there have been both major and minor revisions, with

one major revision being the removal of homosexuality between *DSM-II* and *DSM-III*. *DSM-III* is considered a "landmark" text as it introduced more explicit diagnostic criteria and took a "descriptive approach that attempted to be neutral" about the causes of psychiatric conditions (Price & Siebers, 2011, p. 34). Newer versions (*DSM-IV* and *DSM-V*) have kept the same scientific, positivist tone but have incorporated the perspectives of more clinicians and even some patients.

McCarthy (1991, 1992, 1994) produced groundbreaking rhetorical research on the *DSM*. She first examined how the document shaped one child psychiatrist's experiences in addition to the mental health practitioner community as a whole. Based on this study, she defined the *DSM* as a "charter document," "a document defining as authoritative certain ways of seeing, deflecting attention from other ways, stabilizing a reality, setting the terms of/for future discussions (Reynolds, 2018, p. 7). Berkenkotter (2001) takes a similar stance as she uses the concept of genre systems to examine how the *DSM* influenced individual mental health practitioners' writing practices. In this study, she could not consider just one text or groups of texts; rather, she had to think in terms of how these practitioners are functioning within a broader system. This system included macrolevel genres and practices—such as the *DSM* and other regulations, like billing and medical codes, that practitioners must follow—as well as microlevel paperwork and interactions with patients. All of the paperwork circulated within the rural mental health clinic that Berkenkotter (2001) studied "serves the institutional function of synchronizing the various kinds of work activity and maintaining an institutional record that may be consulted in the future" (p. 333). The paperwork generated before, during, and after an actual therapy session helps the practitioner move towards a diagnosis that will be shaped by the *DSM*, which then leads to treatment and a bill for services. Because of its significant influence over the situated activities of practitioners at the clinic, Berkenkotter classifies the *DSM* as a "meta-genre," which means that the *DSM*'s primary purpose is to standardize the profession. Furthermore, in the case of the mental health clinic examined in this study—it is the catalyst for changes in discursive practices and creates new genres of writing and paperwork. However, Berkenkotter acknowledges that there is tension between the standardization in the *DSM* and the different theoretical orientations and therapy methods that mental health practitioners subscribe to, which has led to the removal or addition of some conditions. The types of conditions that get removed

or added are often influenced by political or social issues (like removing homosexuality and adding PTSD).

Other scholarship has also explored the standardizing effects of the DSM from several different angles. For example, Berkenkotter (2008) performs a rhetorical and genre analysis of the history of psychiatry, focusing on the two opposing forces that influence mental health care today: attending to clients' personal needs and experiences (i.e., serving as a "healer") versus following *DSM* protocols for diagnosis (i.e., serving as "clinician"). Her work also focuses on how client narratives turn into medical terminology/diagnoses dictated by the *DSM*. Emmons & Emmons' (2010) work is similar, except they focus on the gendered language surrounding depression and how, at one point, those living with depression were silenced, but now the language surrounding depression (in the *DSM*, in self-care books, on WebMD, in pharmaceutical ads, etc.) dictates how people can experience and describe their own condition. Similar to Berkenkotter (2001), Emmons & Emmons (2010) characterize the *DSM* as "means of organizing social (inter)actions and activities" (p. 157) since the genres circulated within the mental health system often repeat "terminology and standard linguistic structures" represented within the *DSM* (p. 159). For Emmons & Emmons (2010), those genres are not only ones used by mental health professionals, but also those circulated throughout the public, such as pharmaceutical advertisements and quizzes through sites like WebMD, which are meant to help individuals determine if they are at-risk of having depression or other mental health disorders. Therefore, they concluded that the *DSM's* standardizing effect reaches beyond the clinic and into everyday activities and interactions.

Price & Seibers (2011) suggest that the *DSM*'s overarching influence, along with its increasing length with each edition, seems "to suggest that human life is a form of mental illness" (p. 3). They reference several critics of the *DSM* (particularly *DSM-III*) who see it as a shift toward a biomedical approach to psychiatry that assigns more power to researchers and the pharmaceutical industry rather than clinicians who actually work with patients. Furthermore, they see this shift as a way to claim objectivity that then allows "the manual to begin to seem 'natural'—not made by human hands" (Price & Seibers, 2011, qtd. p. 34). Despite these criticisms, Price & Seibers argue that many people "tend to accept psychiatric rhetoric [in the *DSM*] on its own terms: as an objective, benign, and stable authority" (pp. 36-37).

On the contrary, Holladay's (2017) study of participants' behaviors in an online mental health discussion forum seems to suggest that everyday people are actually quite critical of the *DSM* and the mental health institution as a whole. Participants in this forum help each other "interpret and manipulate medical knowledge in unique ways that benefit the community" (p. 8). Holladay characterizes these participants as "extra- and intrainstitutional actors" who use psychiatric documents "tactically" to deal with "everyday struggles and pleasures" yet are "thoroughly enmeshed within institutional practices" that "impose order and conformity" over the mental health field (p. 8). As the study progressed, Holladay identified several key rhetorical moves within the online community: 1) building ethos through an understanding of scientific terminology and documents (namely, the *DSM*); 2) showing how diagnoses manifest in individual cases; 3) sharing information about medical institutions and support services; and 4) arguing for more inclusive diagnostic language that speaks to individual lived experience. This last move seems to be a rebuke against psychiatry's alignment with the biomedical "by focusing its diagnostic treatment and practices on biological and neurochemical factors" (Holladay, 2017, p. 10). The most current version of the *DSM* embodies the biomedical because "it aims to provide observation-based descriptions of discrete mental disorders to facilitate and standardize individual treatments," and it privileges "clinical trials, generalizable diagnoses, and pharmaceutical intervention" over other forms of treatment (Holladay, 2017, p. 10). Therefore, in an effort to subvert the *DSM*, Holladay suggests that people outside the mental health institution (i.e., patients who it attempts to categorize) should help contribute to the document as well as to other institutional practices.

2.5.1 Public Policy, Legislation, and Advocacy in MHRR and RHM

While the *DSM* has justifiably been a primary focus of MHRR, the field has devoted less attention to other texts and discursive systems that affect mental health outcomes—namely, policy/legislation and advocacy initiatives. Since the 115th and 116th Congresses introduced upwards of 27 bills that address mental health in some form (Mental Health American, n.d.a), it is imperative to interrogate how such documents may affect mental health care and treatment. In turn, understanding how advocacy groups, such as nonprofits, might influence this legislation can also enable MHRR practitioners to develop strategies and best practices for intervening in

the legislative process and communicating with elected officials about the importance of mental health.

Markel (2010) defines public policy and legislation as "official texts that define and explain permissible and impermissible actions by individuals and collectives such as organizations, corporations, and government entities" (p. 26). In other words, public policy and legislation, as examples of professional documents, have the power to dictate individual and collective decisions as well as determine how an individual or an organization can respond and act on a particular issue, which can create roadblocks or difficulties for those attempting to address a problem. McNely & Rivers (2014), borrowing from Latour, characterize certain types of professional documents, like legislation, as "troublemakers" because they have the ability to "authorize, allow, afford, encourage, permit, suggest, influence, block, render possible, [or] forbid," which, in turn, gives them "suasive and palpable relations that significantly shape communication" (p. 1-2). Legislative and public policy documents can be considered "troublemakers" since they can influence, permit, encourage, or block, depending on the context. For example, the Mental Health Parity and Addiction Equity Act (MHPAEA) allows mental health advocacy organizations to more easily direct individuals with mental illnesses and their families to the proper services because, with health insurers required to treat mental illnesses and addiction the same as physical illnesses, individuals and families are more likely able to afford different types of treatments. On the other hand, state legislation that champions involuntary commitment of individuals with mental illnesses or substance abuse disorders can block people and families from making their own crucial healthcare decisions. In this way, like the *DSM*, we might consider legislation and policy as "charter documents" (McCarthy, 1991) or "meta-genres" (Berkenkotter, 2001) within the mental health discursive system.

However, public policy and legislation are not simply "bounded vehicle[s] for rendering judgements"; they are also "a way of seeing and reading the many different ways [they are] always already imbricated in the world" (Hannah, 2010, p. 9). Public policy and legislation are infused into everyday life. Much like the *DSM*, they serve as meta-genres that influence thought/discourse as well as affect people's actions and the choices they make (Albi, 2013). Yet, at the same time, public policy and legislation are also shaped by those same actions and choices, and they are not just the product of dealings among members of the legislative branch. For example, through his examination of federal law on health information technology (health IT)

privacy policies, Markel (2010) found that, in addition to Congress, members of the executive branch, Congress, research organizations, watchdog agencies, interest groups, and "interested nonaffiliated individuals" influenced key pieces of legislation through "subsidiary documents" (p. 26, 29). In contrast to a legislative charter document (different from McCarthy's use of the term), which is "an archival text, such as the U.S. Constitution, ….that is fundamentally important to the community in communicating its values, principles, and … its policies and procedures," a subsidiary document is a "nonarchival text such as a summary, analysis, guide, or critique of the charter text" (Markel, 2010, pp. 28-29). In the case of health IT privacy policy, these documents were created not only by Congress and other government-affiliated institutions but also advocates for privacy, physicians, other health care professionals, and attorneys, and the types of documents produced included a "full range of technical communication media," such as instructional texts, blogs, and podcasts, that was geared toward "audiences as diverse as individuals, employers, health care providers, federal and state government agencies, and journalists" (Markel, 2010, pp. 43-44). As we can see here, these forms of technical communication "directly engage the public policy process," meaning the production of legislation involves not only a variety of genres but also the input from several types of experts (Smith, 2000, p. 78).

Other RHM scholars have also addressed the role of policy and legislation in mental health. For instance, Jack & Applebaum (2010) and Jack (2010) cite the power of neuroscience—in particular neuroimaging—in public opinion and policy. Although the process and method of interpreting brain images is still up for debate within the field of neuroscience, neuroimaging and other forms of neuroscientific evidence have become convincing to the general public, as "researchers found that even including the words 'brain scans indicate' increased readers' confidence in explanations of brain phenomena" (Jack & Applebaum, 2010, p. 429). This has led to what Racine et al. (2005) called neuro-policy—"attempts to use fMRI results to promote political and personal agendas" (p. 161). As an example, mental health researchers have used brain images as evidence to gain support and funding for early intervention in individuals with schizophrenia and other related disorders (Eskenazi Health, n.d.). However, while the policy resulting from brain images may benefit those living with a mental illness, Racine et al. (2005) emphasize that it is imperative to avoid falling into a positivist trap

that upholds all scientific evidence as objective truth. They remind readers that brain images, like other scientific results, are ultimately interpreted by humans.

Similarly, Segal (2005b) demonstrates how the use of metaphors in health/medical discourse reflect our societal values and "constrain not only the outcomes of debate [about health policy] but also what it is possible to argue at all" (116). For example, the metaphor "diagnosis is health" carries significance in health policy in the United States and Canada because both countries' medical/health systems operate through a biomedical model. Additionally, in both countries, health is often discussed in terms of financial/economic concerns, such as the inability to afford health care or the need for funding innovation and research. The metaphors associated with this biomedical/financial model ("the body is a machine," "medicine is war," "medicine is a business," etc.) led to health policy that focuses on developing "treatments, diagnostics," and other types of "observable and measurable" interventions rather than "'determinants of health' such as social class, housing, income, education, exposure to environmental agents, etc." (Segal, 2005b, pp. 120-123).

Other scholarship focuses on how individual doctors, patients, and other stakeholders can intervene in the legal and policymaking process. Schryer et al. (2009) and Spafford et al. (2010) use Star & Griesemer's (1989) concept of boundary objects and Berkenkotter's (2001) genre systems to examine how physicians writing forensic reports and letters in child abuse cases must translate medical information in a way that is both understandable and compelling to audiences such as social workers, law enforcement agents, judges, etc. Both articles show how medical language and evidence can contribute to legal decisions and classifications.

Other studies focus on how some pieces of evidence are valued over others. For instance, Teston et al. (2014) examined the FDA's 2011 Avastin Hearing, which centered around the FDA's decision to no longer approve Avastin for the treatment of breast cancer. After patients, doctors, researchers, and cancer advocacy organizations, expressed concern about the decision, the FDA held a forum to hear their perspectives and to make their case to keep Avastin's designation as one option for breast cancer treatment. Using rhetorical stasis theory, Mol's (2002) multiple ontologies, and Callon et al.'s (2011) concept of "hybrid forums," Teston et al. found that although many types of stakeholders were invited to provide a testimony at the hearing, only certain types of evidence (such as the biomedical) were seriously considered as the FDA was making their decision. This contribution builds on previous rhetorical scholarship that

examines how marginalized voices like patients, or even some physicians, can develop strategies to intervene and advocate in discussions related to health policy (Graham, 2011; Mitchell & McTigue, 2012; Segal, 1993; Spoel & James, 2006).

Despite MHRR practitioners' call for increased patient involvement in decisions regarding mental health outcomes, scholarship that addresses advocacy is minimal, particularly in relation to legislative initiatives. Rather, researchers focus on how advocates strive to reduce the stigma associated with mental health. Stigma is indeed a considerable barrier to achieving better mental health outcomes and also isolates individuals who have experienced mental illness. Johnson (2010) and Molloy (2015) engage with the stigmatizing effects of mental illness and how mental health patients navigate a society that stereotypes mental health conditions. Johnson (2010) uses the "Eagleton Affair" to demonstrate how mental illness serves as a "rhetorical disability." Thomas Eagleton was George McGovern's vice-presidential running mate, but in 1972 he was forced to drop out after revealing that he had previously been hospitalized for depression. Johnson (2010) defines a rhetorical disability as "the barriers that prevent certain rhetors from achieving rhetoricity with certain audiences"—i.e., what prevents them from being heard or understood or recognized as a legitimate authority (p. 461). As Johnson (2010) explains, once revealed, a mental illness often damages the individual's ethos because it becomes a "permanent identity"—a person "has" or "suffers from" a physical condition, but a person with a mental health condition "is depressed" or "is bipolar" (p. 468). In other words, the mental illness becomes enwrapped in the individual's identity, which then affects how others view them and their ability to function in society. Molloy (2015) demonstrates how individuals at an outpatient mental health care facility attempt to recover their credibility and rebuild relationships after they have been diagnosed. She characterizes their efforts as recuperative ethos: "the day-to-day discursive practices through which a person might regain credibility and, as a consequence, rebuild the personal, social, and professional standing that is often compromised in acute phases of mental illness" (pp. 139-140). As Molloy shows, these individuals who have been diagnosed find that they need to both combat stigma and negotiate their relationships with the biomedical system that has defined and labeled their conditions.

Advocacy initiatives have, in part, helped to reduce the stigma against mental illness. Carr (2014), a professor in the School of Psychiatry at University of New South Wales, provides an analysis of rhetorical strategies and techniques that he believes are most effective in mental

health advocacy work. For example, he cites "credibility, trustworthiness, and the status of the persuader" as keys to successful mental health advocacy, although he is skeptical of the role of medical organizations because political officials may believe that they are acting out of self-interest and do not speak for other stakeholders, like patients, families/caregivers, nonprofits, etc. (p. 873). He also suggests "a broad-based coalition of stakeholders[...]with a unified message," including some stakeholders with "financial clout," as well as using appeals to emotions to get politicians to connect to the issue and their own personal experiences (pp. 873-874).

Nonprofit organizations are one type of stakeholder that are actively involved in advocacy initiatives related to mental health, and several MHRR practitioners have rhetorically examined the role of these organizations in different aspects of mental health awareness and support. Uthappa (2017) follows volunteers for a grassroots advocacy group, Speakers Bureau, which gives speeches/presentations about mental illness to high school students. The speakers reveal their own diagnoses and discuss their experiences with mental illness in the hopes of combating stigma and reaching out to young individuals who may be struggling with mental illness themselves. Similarly, Saunders (2018) addresses autism advocacy, and specifically looks at two advocacy groups: Autism Speaks and the Autism Advocacy Network (ASAN). Autism Speaks approaches autism through a biomedical lens and frames it as a disease in need of a cure, whereas ASAN "operates within a disability rights paradigm...and represents autistic people as oppressed citizens" and frames autism in terms of neurodiversity (p. 1). According to Saunders, the organizations invoke two different types of rhetorics to circulate their advocacy initiatives. Autism Speaks uses a "ransom rhetoric [...] to portray autism as a private medical tragedy and create a sense of urgency around finding a cure" (p. 2) ASAN, on the other hand, uses "rights rhetoric to shift attention toward public acceptance and support of neurological difference" (p. 2). In both cases, Uthappa (2017) and Saunders (2018) focus on how the advocacy organizations frame and present mental health and behavioral disorders and how their messages may affect the perceptions of the public.

2.5.2 Bridging the Gap Between Mental Health Advocacy and Policy in RHM

Thus, while MHRR has addressed both policy/legislation and advocacy, that research is primarily confined to individual texts, events, and organizations. Furthermore, it does not consider how policy/legislation and advocacy intertwine to create a discursive system that affects

mental health outcomes, nor how advocacy organizations create and circulate materials aimed at influencing legislation, public policy, and public opinion. Therefore, this dissertation aims to bridge this gap between mental health advocacy and policy in RHM by demonstrating this symbiotic relationship between advocacy materials and legislation.

Throughout the history of the field, the sites of research for RHM have been primarily contained to "set[s] of texts (e.g., medical journal articles, regulatory documents, prescriptions), genres (e.g., professional talks, hospital case presentations, doctor-patient interviews), and discourses (e.g., pharmaceutical discourse, end-of-life discourse, health policy discourse)" (Segal 2009, p. 227). While these studies have been useful in terms of establishing the field and highlighting the inherently rhetorical nature of the healthcare and medical fields, they have generally examined texts, genres, and discourses as "bounded discursive objects" rather than as elements within broader discursive systems. Therefore, rhetoricians of health and medicine are now calling for a "shift in the unit of analysis from … official texts … to the practices that various groups use in contributing to and altering [medical] and health practices" (Keranen, 2014, p. 104) as well as a turn from "static rhetorical situations and elements" to "rhetorical movement and transformation" across "discursive, sociocultural, and material variables" (Jensen, 2015, p. 523). Rather than focusing on textual production from the point of view of medical and healthcare professionals, Keranen (2014) argue for a focus on publics in order "to understand how citizens, institutions, and movements increasingly organize around biological, medical, and health matters" (p. 104). This type of scholarship allows for a more complex view of medical and health discourses and also responds to a changing rhetorical landscape with communication becoming increasingly more networked and distributed.

Therefore, this dissertation answers this call through a case study that examines the rhetorical movements that define the relationship between advocacy and public policy/legislation through one mental health advocacy organization's interactions with the legislative process. While this study focuses on one organization and uses the organization's advocacy materials as some of the primary artifacts of analysis, it moves beyond organizational boundaries to examine how those materials interact with the broader political and social sphere through mental health public policy/legislation, thereby forming an assemblage with components that concertedly affect mental health outcomes. Mental health advocacy initiatives and mental health legislation have rich, complex histories that can illuminate current issues surrounding mental health in the

United States, so it is imperative to consider their impact in addition to foundational medical texts like the *DSM*.

Moreover, as I will further explain in Chapter 3, this dissertation takes a networked infrastructural approach, borrowed from Technical and Professional Communication, to examine how the advocacy materials produced by this organization not only circulate throughout the public but also within the organization itself. This component of the study is particularly important because the organization operates at the national, state, and local levels with offices dispersed throughout the country. This means that, depending on the level of the organization, their advocacy initiatives may be more focused on policy/legislation in specific states or communities. Therefore, legislation from the federal, state, and local levels will also come into play to illustrate the interactions that occur beyond the organization. Ultimately, this dissertation demonstrates how the interactions between advocacy materials and legislation constitute a discursive assemblage that is constantly evolving as priorities and values concerning mental health in the United States shift and attention is diverted to particular issues at different moments in time.

2.6 Conclusion

In this chapter, I have traced significant research in RHM and identified the gaps in the field regarding mental health research. Finally, I have argued that advocacy and public policy/legislation, like the *DSM*, have significant effects on mental health outcomes and should be studied as a network or assemblage of communication rather than as separate texts. In the next chapter, I provide my theoretical framework, which largely draws from Rhetorical Ecologies and Assemblage Theory, and other postmodern rhetorical theories. I use these frameworks as the basis for the methods that make up my case study, which I also describe in Chapter 3.

CHAPTER 3: THEORETICAL FRAMEWORK AND METHODS

3.1 Introduction

Mental health is entangled with many other issues that the United States faces. The Substance Abuse and Mental Health Services Administration (SAMHSA)—the leading authority on federal mental health policy in the United States—lists all their programs and campaigns aimed at improving mental health services on their website. These programs aren't just focused on mental health itself; they also address homelessness, criminal justice, disaster preparedness, tribal affairs, and drug use (SAMHSA, n.d.). As demonstrated in section 1.3.2 (History of Mental Health Policy and Legislation) in Chapter 1, because mental health has been a historically neglected issue, experiencing a mental health condition could have rippling effects on other aspects of a person's life. For example, a serious mental illness that is left untreated could potentially result in an individual losing their home or being arrested and placed in jail. A lack of support/funding for affordable housing or law enforcement training may be just as detrimental to someone with a serious mental health condition as a lack of affordable/accessible treatment. Thus, mental health advocates must pay attention to policy beyond pieces of legislation that are specifically devoted to mental health issues, and they need to communicate with a variety of stakeholders to ensure that all these interrelated issues are addressed.

As this problem suggests, the relationship between mental health advocacy and legislation is highly complex. It involves not only interactions between lawmakers and advocates but also the circulation of materials that reach and affect many different stakeholders. As an example, an advocacy organization, such as the NMHO, may react to a proposed piece of legislation (or to a lack of legislation) by writing letters and other types of correspondence to lawmakers; setting up meetings with legislative aides; providing written or verbal testimony on the issue; informing their members or the general public through news articles, blogs, and press releases; and encouraging their members and the general public to take action through social media or other advocacy initiatives. Then, based on the actions of the advocacy organization and their supporters, lawmakers may choose to revise their policies or even pass a new piece of legislation. In other words, the interactions among lawmakers, advocates, legislative documents,

and advocacy materials all directly impact the lives of everyday people, which is why it is crucial to theorize and understand how legislation and advocacy work together.

Studying such a complex relationship requires an equally complex and nuanced theoretical framework and methodology. Therefore, to conduct my case study for this project, I used Rhetorical Ecologies and Assemblage Theory as the theoretical basis for my methods. I use these two theories in tandem because they share many common themes and core concepts. Rhetorical Ecologies theorizes the transformation of discourses and texts (i.e. the components analyzed in this study) as they circulate through space and time (Edbauer, 2005), while Assemblage Theory focuses on the interactions among components within a system (DeLanda, 2006, 2016; Deleuze & Guattari, 1987). Therefore, the two theories together allow for a comprehensive analysis of the discourses and texts in this study's dataset as well as the ways in which they circulate and interact to affect change within the advocacy-legislative assemblage.

In this chapter, I first discuss rhetorical theory in the wake of postmodernism and posthumanism—in particular focusing on materialist and ecological understandings of rhetoric. Then, I explain the key components of Assemblage Theory, focusing especially on "lines of flight" or "flows," territorialisation, deterritorialisation, and macro, meso, and micro units of analysis. Through this theoretical framework, I demonstrate the relationships among Rhetorical Ecologies, materialism, and Assemblage Theory to show how they, in combination, can be used to theorize legislation, advocacy organizations and advocacy work as rhetorical assemblages.

Ultimately, I draw from these theories to develop my methodology and analyze the materials I collected, a process that I also detail in this chapter. In this section, I first describe my research site and articulate my protocols for collecting documents, conducting interviews, and analyzing all the materials in my dataset. A methodology shaped by Rhetorical Ecologies, materialism, and Assemblage Theory enables me to demonstrate how the advocacy materials and legislation in my dataset interact and influence not only each other but also mental health services and outcomes in the United States.

3.2 Theoretical Framework

3.2.1 Rhetoric in the Wake of Postmodernism and Posthumanism

Ancient Greek and Roman rhetoricians often thought of rhetoric as an art or *techne*, "a kind of influencing of the mind by the means of words" (Plato, 261a-b), the ability to "see all the available means of persuasion" (Aristotle, p. 36), or, in the words of Quintilian, "the art of speaking well" (2.15.38) by "judging and discoursing on civil matters that are put before it with certain persuasiveness, action of the body, and delivery" (2.15.22). At first glance, these definitions may seem simple or rudimentary—and in many ways they do indeed reflect the traditional notions of rhetoric that dominated rhetorical scholarship through the mid-20th century. However, both definitions capture something emphasized by postmodern rhetoricians and theorists: the material effects or the action that occurs as a result of language and discourse.

Kenneth Burke (1969) was perhaps one of the first theorists to build on traditional rhetoric by coining the concept "identification." According to Burke (1969), persuasion cannot occur unless both parties involved in the communicative act are able to identify with each other. This need to identify implies that there is a division between the two parties, so identification is the process through which they are able to overcome that division and join together through common interests, values, beliefs, etc. The concept of identification was influenced by Burke's (1966) notion of language as symbolic action, which means that language not only communicates or *says* something but also *does* something, such as bringing people together. In *Language as Symbolic Action*, Burke introduces the concept of terministic screens, which are the ways in which individuals use terms/concepts to interpret/perceive the world. According to Burke (1966), "any given terminology is a *reflection* of reality, by its very nature as a terminology it must be a *selection* of reality, and to this extent it must function as a *deflection* of reality" (p. 45). In other words, terministic screens direct attention toward some interpretations of the world while at same time diverting attention away from others. Where we focus and divert our attention determines how we shape and represent our realities. As Blakesley (2017) puts it, "In the attempt to reflect reality, one selects terms to represent it, and the choice of some terms rather than others means leaving behind some alternatives" (The Rhetorical Function of Terministic Screens section, para. 1). For example, when someone refers to an individual diagnosed with schizophrenia as a "schizophrenic," the mental illness becomes a terministic

screen that defines an aspect of that person's identity. It directs attention to the illness and diverts attention away from any of their other traits or qualities.

According to Burke (1966), there are different understandings of language and thus two types of terministic screens: scientistic and dramatistic. Scientistic language is concerned with the act of defining, i.e. what a term or symbol is or isn't. Dramatistic language, on the other hand, compels action in some form. As an example, the language in the *DSM* defines what constitutes and doesn't constitute a particular mental health condition (i.e. scientistic language), while a doctor using language to provide a diagnosis to a patient may then compel the patient to seek treatment (i.e. dramatistic language). This relationship between language and action is integral to Burke's conception of rhetoric. In *A Rhetoric of Motives*, he defines rhetoric as "the use of words by human agents to form attitudes or induce actions in other human agents" (p. 41). Thus, Burke believes that the purpose of rhetoric is not simply to change minds, but to get people to act in particular ways that, as Bitzer (1968) claims, "[alter] reality, not by the direct application of energy to objects, but by the creation of discourse which changes reality through the mediation of thought and action" (p. 4). Thus, in these situations, both Burke and Bitzer acknowledge the power of language to induce change.

However, neither Burke nor Bitzer quite get at the real, material affects that occur as a result of these changes or actions. Thus, rhetorical scholars have since used materialist and posthuman theories to further rethink conceptions of rhetoric and acknowledge the relationship between the material and the symbolic. According to Cloud (1994), there are two perspectives on the materiality of rhetoric and discourse—idealist and relativist. The idealist perspective states that rhetoric/discourse has material effects, while the relativist perspective states that "discourse not only influences material reality"; rather, "it is reality," as "all relations economic, political, or ideological, are symbolic in nature" (p. 142). Cloud cites McGee (1982, 2009) as representative of the idealist position. In 1982, McGee first published "A Materialist Conception of Rhetoric," which argues that discourse/language does "not merely represent mental and empirical phenomena"; rather, it facilitates social processes that then have material effects on the world (p. 19). McGee (1982, 2009) also conceptualizes rhetoric "on a continuum" of experiences that range from microrhetorical, sociorhetorical, and macrorhetorical. The microrhetorical is one "specific experience of being persuaded," and the rhetors are simply "people with opinions" interacting with other humans (p. 24). For example, a microrhetorical experience might occur

during a private conversation about a political issue. In a sociorhetorical experience, however, the rhetor is playing a role based on membership in a particular social group—like a particular profession—and the opinion or view that they communicate is representative of the social group and not them as an individual. So, for instance, someone who is a mental health professional could discuss mental health as a political issue amongst their friends, which would be a microrhetorical experience. Then, in another context, they may speak on behalf of their profession as an expert to persuade politicians to fund a research program, which would constitute a sociorhetorical experience. Finally, in macrorhetorical experiences, institutions (like governments, legislative bodies, or organizations) are "endowed with human characteristics … including the ability to persuade" and rhetors speak for or as the institution (McGee, 2009, p. 27). For example, spokespeople for a nonprofit organization are speaking on behalf or *as* that institution, not necessarily as individuals. In any case, for McGee, discourse serves as a "medium, a bridge among human beings, the social equivalent of a verb in a sentence" (Biesecker & Lucaites, p. 4). What's important are the relationships that form through the social processes of rhetoric and the material changes that result from those relationships.

Greene (1998, 2009), on the other hand, is a relativist who instead views rhetoric as a form of technology. He believes there should be "more emphasis on how rhetoric functions in a series of institutions as a technology of deliberation," meaning that rhetoric "distribut[es] discourses, institutions, and populations" in order to perpetuate particular narratives and conversations (Greene, 1998, p. 21). According to Greene (1998), this view of rhetoric allows us to uncover power structures and call attention to the ways in which those structures manipulate and control. Greene is particularly interested in the creation of rhetorical subjects and rhetorical agency. The rhetorical subject is "a subject that speaks and is spoken to" (Greene, 2009, p. 49). Individuals become rhetorical subjects when they "utilize[e] sign systems" within a system/apparatus, and also when sign systems are used to manipulate thought and action act in particular ways (Greene, 2009, p. 52). For example, children become rhetorical subjects within the educational system when they first attend school and begin communicating with their teachers and other schoolchildren. As children attend school, the educational system inculcates certain behaviors and norms, such as raising their hands before speaking or addressing teachers using formal titles like "Mr." and "Ms." Because they are being acted upon by this structure, they are in turn acting in particular ways that conform to those structural values.

Greene's conception of the rhetorical subject seems to be informed by Foucault's (1969) *énoncé* or statement. According to Foucault (1969), "If a proposition, a sentence, a group of signs can be called 'statement,' it is not because someone happened to speak them or put them into some concrete form of writing; it is because the position of the subject can be assigned" (p. 95-96). Essentially, Foucault is saying that social norms and the systems/apparatuses that form them dictate what sorts of statements can be made in particular contexts. Systems of statements are what Foucault calls "discursive formations," which Buchanen (2018) says are "produced by force of a single discursive practice," i.e., "the underpinning system of rules of a particular society at a certain moment in history" (Discursive Formation section, para. 1). A discursive formation is not the result of a singular entity with great power or influence; rather, it emerges over time through interactions among institutions, individuals, language, etc. In other words, discursive formations are dispersed across subjects, and it is through these relationships and social processes that language and discourse gets circulated and then, in turn, creates material change.

The concept of circulation, through the lens of posthuman and new materialist theories, has in fact resulted in even more complex interpretations and understandings of rhetoric. For instance, Rhetorical Ecologies, which reexamines the traditional Bitzerian rhetorical situation that treats texts and communication as static and isolated entities, highlights the dispersed, circulatory, networked movement of communication. This notion of rhetoric, first proposed by Edbauer (2005), frames rhetorical situations as operating "within a network of lived practical consciousness or structures of feeling" (p. 5). According to Edbauer (2005), "a given rhetoric is not contained by the elements that comprise its rhetorical situation (exigence, rhetor, audience, constraints). Rather, a rhetoric emerges already infected by the viral intensities that are circulating in the social field" (p. 15). In other words, Edbauer argues that we must move beyond the concept of rhetorical situation and take into account the historical and social processes that surround and interact with texts, media, and other forms of communication. Chaput (2010) builds on this assertation by describing rhetoric as "not an isolated instance or even a series of instances but a circulation of exchanges, the whole of which govern our individual and collective decisions" (p. 8). This theory, according to Scott et al. (2013), "allows rhetorical scholars interested in medicine and health to address more fully the constellation of symbolic and material rhetorics that influence daily life and public meanings and practice" (p. 2).

Rhetorical Ecologies and related theories highlight several tensions in the field: one "between modernist, textualist approaches … and non- or even post-modern, post-human approaches that stress materiality and practice" (Keranen, 2013, p. 5), and another between the discursive and the material in general. One such related theory is Warner's (2002) conception of publics as "intertextual social spaces organized and recognizable through interlinked and ongoing discursive action" (Scott, 2014, p. 230). This understanding of publics, Scott (2014) argues, bridges the gap between the material and the discursive as "in one sense … publics can be thought of as the shifting effects of rhetoric and circulation" while, in another sense, they "can be formed by and comprised of embodied actors that assemble and act in and across materially conditioned contexts" (p. 230). In this case, the "actors" in my study are not only humans—such as legislators, members of the organization, or individuals who use their services—but they are also the documents and communication that circulate within the organization and from the federal level all the way down to the local. A theory of publics—in addition to a systems or networked theory—provides a direction for studying how these documents and genres move and impact different contexts of healthcare advocacy.

To perform research that situates documentation and genres as actors, it is crucial to move beyond the static approaches that previously dominated the field and embrace postmodern theories and methods that allow us to "account for the complexities of language as social action" and examine "the networks, ecologies, and activity systems that shape health-related discourse and its effects" (Scott et al., p. 3). Posthumanist and new materialist theories in particular can advance understandings of how the material and discursive mesh in the distributed, entangled documentation of a mental health advocacy organization.

3.2.2 Assemblage Theory

Specifically, the concept of the assemblage is useful for this project. First introduced by Deleuze & Guattari (1987), an assemblage is "a multiplicity" which "necessarily acts on semiotic flows, material flows, and social flows simultaneously" (p. 23). In other words, an assemblage is a multiplicity of connections and arrangements of component parts that are not stable or fixed within a set boundary. Deleuze and Guattari (1987) liken an assemblage to a rhizome, which, unlike a tree or root, has "no [fixed] points or positions"; "any point of a rhizome can be connected to anything other"; "a rhizome may be broken, shattered at a given spot, but it will

start up again on one of its old lines, or on new lines" (pp. 7-9). Important to the concept of the assemblage is that there is no "center" or controlling force, thus rejecting the modernist tendency to value deeply-embedded hegemonic structures and privilege human agency. DeLanda (2006) builds on Deleuze & Guattari (1987) by defining assemblages as "wholes whose properties emerge from the interactions between parts," which, in turn, serve as the basis for networks, organizations, and movements (p. 5).

In fact, Assemblage Theory is in many ways similar to Activity Theory and Actor-Network Theory—both common methodologies for professional/technical communication research—because they too are the study of the *interactions among parts*. Activity Theory, as explained by Russell (1997), "traces cognition and behavior … to social interaction" (p. 509). Activity Theory is concerned with the human agents, the environment and the artifacts—such as forms of technology and texts—that exist in a system, but the primary object of analysis is the social dynamics that exist among them (Russell, 1997). Actor-Network Theory is similar to Activity Theory in that it also involves the study of systems and networks—and is concerned with the "material surroundings of communicators" and the artifacts, or nodes, within a system (McNely et al., 2015, p. 2). Actor-Network Theory also aims to reveal a particular phenomenon through the process of analyzing the associations among the nodes. However, Actor-Network Theory ascribes agency to both human and nonhuman actors—and does not privilege one over the other—while Activity Theory emphasizes human "consciousness and motive" mediated within a system (McNely et al., 2015, p. 3).

Actor-Network Theory and Assemblage Theory are perhaps the most closely related to each other. Both theories address how entities emerge and what holds them together. However, while Actor-Network Theory is most concerned with the associations that exist among nodes in the network, Assemblage Theory places more emphasis on how the components and the assemblage as a whole react to each other through ongoing feedback loops that, through each interaction, causes alterations to the individual components and the whole (DeLanda, 2006, Muller & Schurr, 2016). Therefore, Assemblage Theory focuses on the communication lines within the assemblage and how they affect both the individual components and the assemblage as a whole. DeLanda (2016) also regards the components of an assemblage as assemblages themselves meaning that "at all times we are dealing with assemblages of assemblages" (p. 3). In other words, the components that make up one assemblage are also an ensemble of parts with

unique histories and emergent properties: “the properties of a whole caused by the interactions between its parts” (DeLanda, 2016, p. 9). Institutions of higher education are one example of an assemblage because while a university is often one whole entity, it is comprised of many different parts—some larger, like schools or colleges that house particular majors or areas of study, and some smaller, like individual staff, faculty, and students. A university’s function and identity emerge from the interactions among these parts, as a university would not exist without students attending classes or faculty conducting research.

Nail (2017), citing the work of Deleuze & Guatarri, says that all assemblages have a basic structure that includes the abstract machine, the concrete assemblage, and the personae. The abstract machine is, essentially, the relations that tie together all the different components of the assemblage, while the concrete assemblage is the specific arrangement of the components within an assemblage as a result of their relations. An example that Nail (2017) provides is the constellation Ursa Major: the abstract machine is the relations among the stars and the concrete assemblage is the physical stars that are connected. Finally, the personae are “the mobile operators that connect the concrete elements together according to their abstract relations” (Nail, 2017, p. 27). They are, essentially, what keeps the assemblage together in a particular moment. In terms of Ursa Major, we might say that the human mind and eyes are the personae because they are the ones who recognized the pattern among the stars and then named it. Or, if we’re thinking in terms of how they are able to physically stay in that pattern, we could say that gravity is the personae. If we continue with the example of a university, the concrete assemblage would be the physical campus—the academic buildings, the dining halls, the roads and sidewalks connecting them—and the individuals who inhabit the campus—students, faculty, staff, visitors, etc. The abstract machine would be all the symbolic connections and the relationships among those physical components, and the personae are what forge those connections. For example, some faculty, staff, and students are connected because they are all involved in a particular major or program that is defined by the language/terminology used in a particular area of study. With this terminology, Nail (2017), Deleuze & Guattari (1987), and DeLanda (2006, 2016) develop a logic and vocabulary that enables assemblages to be theorized.

However, Buchanen (2015, 2017), DeLanda (2006, 2016), and Nail (2017) also point to problems with the concept of assemblage. Assemblage is the translation used for Deleuze and Guattari’s original term *agencement*, which “refers to the action of matching or fitting together a

series of components...as well as to the result of such action: an ensemble of parts that mesh well together" (DeLanda, 2016, p. 1). *Agencement* stems from the verb *agencer*, which means "to arrange, to lay out, to piece together"; therefore, *agencement* actually means "a construction, an arrangement, or a layout" (Nail, 2017 p. 22). However, the English word assemblage, which comes from the French word *assemblage* (a-sahn-blazh), means "the joining of union of two things" or "a bringing or coming together" (Nail, 2017, p. 22). Thus, the English translation does not completely capture Deleuze & Guattari's original concept. An arrangement or a layout is much different than a union or a gathering, as the latter implies unity and homogeneity, while the former rejects "unity in favor of multiplicity" and heterogeneity (Nail, 2017, p. 22). A closer term might be an "assembly" because it has that sense of being self-organized for a common purpose.

Nonetheless, scholars use the term assemblage as the alternative to a unity. A unity consists of *relations of interiority*, which mean that it "cannot subsist independently of the relations that they have with each other" (DeLanda, 2016, p. 10). One example Nail (2017) offers is the human body: a human body cannot work without all (or at least almost all) of its organs, and none of the organs will work outside of the human body. According to DeLanda (2016), assemblages, on the other hand, consist of *relations of exteriority* that are always in a state of *emergence*. Relations of exteriority mean that components within an assemblage "retain their autonomy, so that they can be detached from one whole and plugged into another one, entering into new interactions" (DeLanda, 2016, p. 10). In other words, unlike an organ, a component in an assemblage—like a person or a document—can circulate throughout an assemblage and interact with any number of other components. Emergence means that the assemblage is constantly changing or evolving because of those interactions among its autonomous components. For example, a student is an autonomous person that exists independently from the university and is a part of other assemblages at different points in their life. Additionally, that student's interactions with other components in the university assemblage—like faculty members, campus organizations, fellow students, etc.—invoke changes that alter the university in some way, no matter how small. For example, several students may decide to form a new club that eventually becomes popular and then begins hosting events on campus. This new club doesn't necessarily alter the mission and vision of the university or create

any sort of widespread change, but it does add another component to the assemblage that then generates more interactions with other components.

In fact, Assemblage Theory is more interested in the interactions (i.e. communications) among the elements of the assemblage rather than the elements themselves. These interactions define an assemblage's identity and enable it to organize and stake claim in particular spaces. The process that an assemblage goes through to create a stabilizing identity is called *territorialisation* (DeLanda, 2016; Deleuze & Guattari, 1987). One way an assemblage territorialises is by establishing norms and conventions and developing internal procedures and processes. A university territorialises through texts such as its mission statement, an honor code, grading policies, and another type of procedure it implements to standardize and organize its components. The goal of territorialisation is to homogenize its components, which Deleuze & Guattari (1987) and DeLanda (2016) call the process of *coding*. However, because of the autonomy of its components, assemblages are also capable of what is called *deterritorialisation*, which is when a component attempts to change or re-invent the assemblage in some way. Deterritorialisation is sometimes accompanied by *reterritorialisation*, which is when an assemblage gets restructured in some way. Deterritorialisation often creates *lines of flight* or *flows* that alter or expand the assemblage. For example, universities often have some form of student government, and that organization may push the university administration to add, change, or eliminate a policy or procedure that they feel doesn't serve the best interests of students. Nail (2017) identifies four types of deterritorialisation:

- *Relative negative deterritorialisation:* lines of flight or flows that cause an established assemblage to adapt or change while still maintaining its inherent structures. An example Nail (2017) provides is when governments adapt their policies based on lobbying or popular demand (such as through the efforts of advocacy movements). If university officials decide to make a policy change that the student government suggests, that would be another example of relative negative deterritorialisation.
- *Relative positive deterritorialisation*: lines of flight or flows that "escape the established assemblage" but have not yet produced radical change nor have been co-opted by another assemblage. They are ambiguous and simply "possibilities of a new world" (p. 35). For example, graduate students on some campuses have attempted to form unions in order to negotiate for better pay and working conditions. In some cases, those unions are

recognized by the university and they are able to use their leverage to better their situations. However, in other instances, they end up becoming more of a "rogue" organization that still attempts to enact change but is not officially endorsed and absorbed into the fabric of the university.

- *Absolute negative deterritorialisation*: lines of flight or flows that "do not support any assemblage, but undermine them all" (p. 34). This type of deterritorialisation tends toward self-destruction because lines of flight or flows need assemblages to stay viable. One example might be a program at a university that is cut either because of budget constraints, or a lack of students registering for the courses.
- *Absolute positive deterritorialisation*: lines of flight or flows that create an entirely new assemblage. This form of deterritorialisation has the potential to create a revolution, or it could simply lead to something new. Nonprofit foundations that are established by university officials to manage endowments, funding, and intellectual property are examples of absolute positive deterritorialisation because, although they are affiliated with the university, they are still considered separate entities and follow different rules and governance procedures.

Furthermore, if we want to understand a phenomenon, according to Assemblage Theory, we can't only ask what it is, but rather, how it happened, or where it came from. An assemblage is not a "final product" but instead a "network of social and historical processes" (Nail, 2017, p. 24). We cannot define its inherent, essential features because "we know only its collection of contingent features at a certain point in its incomplete process" (Nail, 2017, p. 24). However, Buchanen (2017) argues that assemblages are "structured and structuring" and have a logic that can be mapped (p. 463). This logic or structure is, according to Buchanen (2015) deliberate and purposeful:

> This is how the assemblage works. It always benefits someone or something outside of the assemblage (the body without organs); along the same lines, the assemblage is purposeful, it is not simply a happenstance collocation of people, materials, and actions, but the deliberate realization of a distinctive plan (abstract machine); lastly, the assemblage is a multiplicity, which means its components are both known and integral to its existence, not unknown and undecided. (p. 385)

These components make up "the productive intersection of a form of content (actions, bodies, and things) and a form of expression (affects, words, and ideas)" (Buchanen, 2015, p.

390), or borrowing from Deleuze and Guattari's (1987) original terminology, *machinic assemblages* and *collective assemblages of enunciation*. Machinic assemblages refer to the realm of the material and how physical objects interact and affect each other. Collective assemblages of enunciation, on the other hand, refer to the realm of language and the symbolic or expressive. The realms of the material and the expressive are inextricably linked, although they do not have a direct cause and effect relationship. Rather, collective assemblages of enunciation trigger what Deleuze & Guattari (1987) call *incorporeal transformations*, or the ways in which the expressive can create connections among bodies, actions, and things, which in turn affects how they exist in the world. For example, when a university dignitary speaking at a graduation ceremony publicly confers candidates' degrees, the graduates have not been physically changed in any way. However, the official attainment of that degree changes how others perceive them and can therefore alter the material conditions in which they live, such as by enabling them to start a career and earn more income. Thus, in order to analyze an assemblage, both the material and the expressive as well as their interactions must be taken into account.

Assemblage Theory has several parallels with Burke (1966, 1969), Rhetorical Ecologies, and the institutional/organizational theories described in Chapter 2. First, much like an assemblage's relations of exteriority, the process of identification acknowledges that it is what exists between or among individuals, like a common cause or common interests, that brings them together. Typically, identification is applied on an individual level, but we might say that assemblages are held together with a more collective form of identification—since the components of an assemblage are often connected by something that they have in common, like an institution of higher education or, in the case of my project, a vested interest in mental health issues. Relatedly, a terministic screen could serve as a sort of territorialising frame that shapes those relations as well as the flow of communication within the assemblage. For example, a more STEM-focused university will most likely direct more attention toward majors like computer science and engineering rather than liberal arts majors. This may then result in more publicity for those majors and more students pursing them.

Second, Edbauer's (2005) Rhetorical Ecologies aligns well with Assemblage Theory because both are concerned with the movement and emergence of communication. Assemblage Theory acknowledges that the components in an assemblage have their own identities outside of the assemblage itself and, therefore, they can go off and produce flows or "lines of flight" that

expand or disrupt the assemblage in unintended ways. The same applies to Rhetorical Ecologies. When a piece of media is sent out into the world, it is often repurposed and used in ways that were not intended by the "original" author. For instance, it's not uncommon for student clubs/organizations to use memes, which are constantly changing as they circulate around the Internet, in their advertisements for events.

Finally, New Institutional Theory, which I reviewed in Chapter 2, contends that institutions and organization, like assemblages, are in a constant state of emergence (Baba et al., 2012; Brown et al., 2012; Cloutier & Langley, 2013). An institution/organization's internal components (employees, technology, office space, etc.) are always interacting with each other and forces external to the institution/organization. It is through these interactions that the institution/organization gains its identity and is able to expand or exert influence. A component may be able to deterritorialise an institution/organization, and on the other hand, the institution/organization as a whole can territorialise its components through an institutional logic that creates a stable identity. I contend that the mental health legislative-advocacy assemblage that I examine in this project functions in a similar way to an institution/organization, as it exists in a constant push and pull between territorialisation and deterritorialisation.

3.2.3 Assemblage Theory in Rhetoric and Composition and the Social Sciences

The assemblage has infiltrated both theoretical and empirical work in Rhetoric and Composition. In terms of theory, we see an emphasis on the suasive power of assemblages and how they are not human-centric or human-driven. According to Nicotra (2016), assemblages produce actions that "come about not as products of deliberate human decisions, but from a heterogeneous, distributed agency of many actants, both human and nonhuman" (p. 187). Haraway (2016) states that in an assemblage of various actants, there are no boundaries, and there is no center or driving force. Instead, assemblages are "collectively-producing," have no "self-defined spatial or temporal boundaries," and have power and control "distributed among [their] components" (p. 33). She calls these assemblage "sympoeitic." One way to conceptualize sympoeitic assemblages is through the concept of virality. According to Gries (2015), "a thing is commonly said to be viral when it is perceived as being socially contagious due to its capacity to garner mass attention and spread via word of mouth and media" (p. 2). In fact, a goal of

advocacy initiatives is to, in a sense, "go viral" in order to raise awareness and achieve widespread support.

In the edited collection *Rhetoric, Through Everyday Things*, assemblages and their rhetorical effects are theorized using tangible objects, with a focus on how they make meaning and forge connections with other material objects as well as organic bodies. For instance, Nicotra (2016) examines trash as an assemblage after she moved to Finland and discovered that their waste practices—which include smaller waste baskets and composting—are very different from those in the United States, which, in turn, changed her relationship to trash. And, as Nicotra says, this new relationship to trash was not a conscious, rational decision that she made; rather, she was forced to change her habits because "the material affordances of the new trash assemblage simply did not allow for" her habits that she cultivated with the previous system (p. 190). Similarly, Hallenbeck (2016) examines the emergence and evolution of women's bicycling in the 19th century alongside political and social movements at the time, showing how objects, "such as tricycles and bloomers and bicycle seats" and bicycles themselves can be rhetorical figures that serve as catalysts for change. In both cases, agency is not held or concentrated within the individual; instead, it is distributed across the elements within an assemblage: the home, the bins, the recycling truck, the Finnish government, the bicycle, the women's bicycle wear, etc. Thus, from these examples, we see rhetoric as "a distributed event that unfolds with time in and across networks of complex, dynamic relations" (Gries, 2015, p. 155). This interpretation of rhetoric is useful for understanding the relationship between advocacy and legislation as both institutions consist of material, rhetorical components that interact and change as a result of the social processes that make up the United States government and healthcare system.

In terms of empirical work in Rhetoric and Composition, Ehrenfeld and Angeli use Rhetorical Ecologies and Assemblage Theory to ground their methodologies in both of their chapters in *Methodologies for the Rhetoric of Health and Medicine* (2017). In his chapter, Ehrenfeld (2017) argues that the field needs more methodologies that "consider the complex material-semiotic infrastructures that are central to the study of circulating health and medical knowledge" and "enable us to more fully consider the reflexive relationships that exist between rhetorical practices and the material-semiotic infrastructures that undergird complex ecologies of circulation" (pp. 41-42). Similarly, Angeli (2017) proposes a methodological framework based on Assemblage Theory that she calls assemblage mapping, which "can be used to approach

challenging, dynamic, and even unpredictable research sites" by mapping "a project's tangible and intangible components to see how these components interact" (pp. 236-237). Angeli includes stakeholders, communication channels, power dynamics, and shared values among the list of components that should be included in an assemblage map. Assemblage mapping does not offer any methods that help researchers collect data; however, it "complements current research methodologies that RHM researchers employ, like focus groups, ethnography, and case studies, by turning the focus to external components, values, and power relationships that impact a research project and its methods" (p. 299). Assemblage mapping is integral to my project, as I create my own maps of the mental health legislative-advocacy assemblage that emerges from the data I collected.

Social science researchers have also used Assemblage Theory to develop new materialist methods for social inquiry. For example, Fox & Alldred (2015) describe how the concepts *affect* and territorialisation—which are integral to describing assemblages and explaining how they form and behave—can be utilized for social science research. Affect, "meaning simply the capacity to affect or be affected," is essentially the replacement for the concept of human agency, because "In an assemblage, … no single object possesses agency … rather, an affect is 'becoming' that represents a change of state or capacities of an entity," whether that change is "physical, psychological, emotional, or social" (p. 401). Fox & Alldred (2015) describe these changes as "affective flows" with "capacities for action, interaction, feeling, and desire produced in bodies or groups of bodies," with the term "body" referring to any type of entity, whether human or non-human (p. 402).

These affective flows then either territorialise or de-territorialise, meaning they either stabilize an assemblage or de-stabilize it, causing rifts or "lines of flight" that expand and reconstitute the assemblage (Fox & Alldred, 2015). Two types of affective flows, aggregative and singular, either territorialise or deterritorialise. Aggregative flows territorialise as they "assemble and systematize bodies and things into collectivities" while singular flows "possess no aggregative capacity and on occasion may deterritorialise and fragment assemblages, producing 'lines of flight' away from stable or organized formations or classifications" (Fox & Alldred, 2015). For instance, a new dress code policy could be an attempt to standardize an organization and ensure that all employees are presenting themselves with a particular image. The dress code would be an aggregative flow that attempts to territorialise. However, that policy could

potentially be unpopular and, depending on how its enforced, could diminish employees' trust in the organization and cause them to leave. In that case, the aggregative flow leads to singular flows (employees quitting) that deterritorialise the organization. Thus, these interactions within an assemblage produce change either through strengthening connections, weakening them, or creating new ones that redefine it.

Also, rhetoricians who use social science methods tend to analyze organizations in three levels: micro, meso, and macro. According to Fox & Allred (2015), "assemblages comprise elements from these different 'levels' … and the affective flows between these elements are rhizomic rather than 'top-down' or 'bottom-up'" (p. 402). In the social sciences, macro, meso, and micro commonly correspond to nations/societies, communities/states/organizations, and individuals. Moreover, the scale of the different levels within an assemblage is relative to its other components. For example, a person is micro compared to a community, but a community is micro compared to a larger social justice movement. And, further, that movement is micro compared to a government. These principles complement DeLanda's (2006, 2016) concept of nested assemblages, which distinguishes between micro or molecular assemblages (like individual humans) and macro or molar assemblages (like a government).

The most prominent example of this type of research from Rhetoric and Composition is Spinuzzi (2003), who develops a method called *genre tracing* that provides researchers with a way to examine how workplace practices and artifacts emerge based on three units of analysis: the *macroscopic*, *mesoscopic*, and *microscopic*. Although Spinuzzi does not directly engage with Assemblage Theory, his units of analysis are comparable to those mentioned in the previous paragraph. The macroscopic refers to how culture and societal norms help to shape genres. The mesoscopic refers to how a genre is operationalized within an organization. And the microscopic refers to the genre's basic features that become habitualized over time. Using the memo as an example, on the macroscopic level, the function, format, and purpose of memos emerged over time due to institutional and cultural norms. On the mesoscopic level, memos might be structured slightly differently or use varying tones or levels of formality depending on the particular organization. Finally, on the microscopic level, all memos typically share the same common features, like a header, that have been used consistently over time. Although I do not use the genre tracing method for this dissertation, these layers of genre analysis reflect this project's dual emphasis on the NMHO's advocacy materials as discrete artifacts and with how those materials

collectively contribute to organizational advocacy initiatives. These terms will also help to expand my purview beyond the organization itself, as its activity is shaped by its interactions with policy and legislation.

Another example of an empirical study inspired by Assemblage Theory is Laurie Gries' (2015) *Still Life with Rhetoric: A New Materialist Approach to Visual Rhetorics*. Gries uses the notion of the assemblage and the logic of the viral to track the rhetorical, circulatory, viral life of the Obama Hope poster. To more effectively approach rhetorical circulation, Gries developed a new method: iconographic tracking. This method "makes use of traditional qualitative strategies such as questionnaires, interviews, and field study as well as inventive digital research strategies to collect, organize, and visualize data" and "to describe not only how images spread and transform but also how they reassemble collective life through a variety of rhetorical endeavors" (Gries, 2015, p. 110). Iconographic tracking takes place in three phases. During the first phase, researchers are advised to follow the theory of dèrive, where they "embrace uncertainty and the spirit of discovery" by allowing themselves to aimlessly wander through cyberspace in order to articulate multiple paths (Gries, 2015, p. 113). The second phase entails assembling data from the various paths and mining it for trends and patterns. Finally, the third phase requires "a recursive process that fluctuates between data mining and assembling a collection" which "helps discover an image's specific remixes and unintended consequences as well as particular networks of collectives in which the image has played a major role" (Gries, 2015, p. 113). Essentially, researchers attend to certain material processes associated with each chosen path: composition, production, transformation, distribution, circulation, assemblage, and consequentiality. This new materialist approach allows rhetorical researchers to study complex assemblages, like viral phenomena or social media platforms, using systematized empirical methods that produce data-driven evidence. The primary difference between my project and Gries' work is that while she focused on how one image circulated and, thus, evolved, throughout a variety of spaces and contexts, I examine how a system of language, documents, and media interact and, therefore, affect each other and the system as a whole. This difference is why I chose to develop my own methods, rather than using an existing one.

3.3 Methods

Rhetorical Ecologies, materialism, and Assemblage Theory together form the basis for my methods, which I detail in the subsequent sections. I begin by describing my research site—i.e. the organization that is the subject of this case study—and my process for establishing reciprocity and obtaining IRB approval. Then, I illustrate each phase of this study, starting with document collection. I first explain my criteria and system for compiling and storing documents. I also provide an overview/summary of the types of documents included in the dataset. Then, I move on to the interviewing phase and describe my process for recruiting interviewees, provide vocational information about the interviewees, and present the interview questions. Next, I discuss the third phase, assemblage mapping, where I developed diagrams that illustrate the communication channels and power dynamics that exist among all the stakeholders/components involved in this study. Finally, in Phase 4, I describe my process for coding and analyzing the interviews, legislation, and advocacy materials to demonstrate the interactions amongst documents/components in the advocacy-legislative assemblage and how those interactions affect mental health outcomes in the United States.

3.3.1 The Research Site

The subject of this case study is a mental health nonprofit (referred to as the National Mental Health Organization, or NMHO) that promotes mental health awareness and provides outreach and support to those affected by mental illness. The NMHO operates on three tiers or levels:

- a national office that handles federal advocacy priorities, organizational branding, and promotional/educational materials (referred to as NMHO National in this study)
- state organizations that handle state advocacy priorities, promotional/educational materials, and volunteer training materials
- local affiliates that handle local advocacy/outreach and provide support groups, educational courses, and presentations to the community

For this project, I collected documents and interviewed staff members from the NMHO National office, their Indiana state organization (NMHO Indiana), and one local affiliate in Western Indiana (NMHO Local). Mental healthcare in the United States is a complex network

with laws, regulations, and protocols at national, state, and local levels. It is difficult to discuss mental health policy and advocacy without considering each of these levels and how they interact since advocacy initiatives—no matter if they're coordinated locally or nationally—will be affected by national, state, and local issues. I chose to work with the NMHO because they interact with policy at all levels, thereby enabling me to observe how their documentation operates at the national, state, and local levels. Furthermore, since the NMHO works with legislators, mental health professionals, and individuals in the communities that they serve, I have been able to examine the different rhetorical aspects of advocacy work at these different levels.

Additionally, mental health is often an overlooked component of healthcare. Although mental health parity laws dictate that mental health must be treated equally to other types of healthcare covered by insurance, many people living in the United States do not have adequate healthcare and their access to mental health services is even more limited. According to Varrell (2017), over 55% of U.S. counties do not have psychiatrists, and regions that do have mental health providers simply do not have enough of them to support the local populations. Therefore, another reason I have chosen the NMHO is because a major component of advocacy work is calling attention to important issues that have been neglected or ill-handled in the past, and the NMHO has been successful at helping to bring mental health to the forefront of healthcare policy.

3.3.2 Reciprocity

I must also admit that my choosing to partner with the NMHO was, in some ways, a matter of convenience as well as a personal decision. When I first started my project, I had originally intended to work with a different organization (one that advocates for federally qualified community health centers) and had tentatively begun collecting some documents and attempting to develop relationships with staff members. However, although I was able to connect with their Policy Analyst and gain some valuable information from our conversation, I was not able to continue the partnership because I could not get approval from the organization's CEO, and the employee whom I spoke with ended up leaving her position.

My dissertation director and a fellow colleague, both who had established relationships with the local NMHO, connected me with their (now former) Executive Director who from the

start was supportive of the vision for my project and offered to provide me with documents and any other information that I needed. However, I did not want to simply take on the "researcher" role—someone who comes in and takes information and uses it for their own professional purposes. I wanted to give back to the organization, develop relationships, and immerse myself in their mission. Therefore, after this initial meeting, I began volunteering with the NMHO by updating their membership databases and producing content for a monthly newsletter. I am now the local NMHO's newsletter editor, and I will also occasionally work their booth at events and copyedit or revise other documents that they produce. It turns out that this partnership was the best for me both professionally and personally. As I mentioned in Chapter 1, for as long as I can remember, I have struggled with anxiety, especially in social situations, but it wasn't until recently that I actually admitted to myself that I had a problem. It was my blossoming partnership with the NMHO that inspired me to begin therapy. Although I have since left therapy, that experience further strengthened my bond with the organization. I am confident that I will continue volunteering even after the conclusion of this project.

3.3.3 IRB Approval

Before I began conducting this case study, I received approval from Purdue's Institutional Review Board (IRB). This was a necessary step because of my interactions with staff members at the different levels of the NMHO through interviews. My IRB protocol includes the following:

- my project narrative, which explains my research rationale, procedures, participant inclusion and exclusion criteria, recruitment and informed consent, confidentiality, and potential risks and benefits
- the recruitment email I sent to potential participants (see Appendix A)
- the informed consent form (see Appendix B)

It was important for the participants to fill out an informed consent form so that they knew how I would be using the documents and so they knew how they would be represented in my study. I also recorded each of my interviews and made sure that my use of a recording device was communicated in the informed consent form, and I obtained explicit verbal permission from each of the interviewees. IRB approval was also sought in order to protect the identities of my participants. Although I cannot guarantee complete confidentiality, I have used pseudonyms both

for the organization itself and each of the participants. I have also stored the interview audio files, transcript, and the key that connects their pseudonyms to their positions and their actual names in a password protected folder on my personal computer.

3.3.4 Timeline and Major Phases of the Case Study

I first met with NMHO Local staff members and began volunteering in February 2017. I then began familiarizing myself with the structure of the organization, researching mental health advocacy initiatives, and tentatively collecting documents in preparation for my prospectus defense. I first focused on collecting mental health legislation at the federal, state (Indiana, specifically), and local level, since it is publicly accessible online. I had originally intended to collect not only NMHO advocacy documents but also anything that might signify the connection among the different levels of the organization, such as marketing materials. However, the number of documents that accumulated quickly became overwhelming, so I narrowed my focus to only documents that addressed advocacy and public policy. I continued accumulating documents until June 2019 when I began analyzing my data.

As I was accumulating documents, I conducted interviews with staff members from the three levels of the organization. These interviews, which occurred both in-person and over the phone, took place September-November 2018. I then transcribed each interview for data analysis (see Appendix C) January-February 2019.

3.3.5 Phase 1: Document Collection

The first phase of this case study involved collecting legislative documents and the NMHO's advocacy materials. The NMHO has been an established organization for approximately 40 years. Due to time constraints, it would be unattainable to analyze all of NMHO's advocacy initiatives throughout the history of their existence, along with every single piece of legislation that has been passed over the last 40 years. Therefore, in deciding which pieces of legislation and NMHO materials to choose, I first had to determine a range of years from which I would collect legislation and advocacy materials. To make this decision, I deferred to my literature review, where I outline the major milestones in healthcare and mental health policy in the United States. In recent history, the most significant piece of healthcare legislation

has been the Affordable Care Act (ACA), which was signed into law by President Barack Obama in 2010. Therefore, all the legislation and advocacy materials I collected were either signed into law or published between the years 2010 and 2019.

Advocacy Materials-NMHO national

My criteria for collecting NMHO documents was simple: they had to cover public policy issues or address advocacy in some form. This included direct calls to action as well as instructional documents on how to perform advocacy. The genres represented include web pages, blogs, news articles, magazines, press releases, reports, white papers, one-pagers, PowerPoints, letters, governance documents, emails, memos, newsletters, fact sheets, and video transcripts. My process for gathering all these materials consisted of several steps. First, I focused on NMHO National. I scoured their website for any web pages or downloadable files that dealt with public policy or advocacy. They have several pages dedicated to explaining their public policy positions, priorities, and social media campaigns, as well as a downloadable PDF of their entire public policy platform. The web pages are geared toward a fairly broad audience, including all members/supporters or potential members, but the Public Policy Platform, a lengthy document with much more considerable detail, seemed to be targeted toward staff or board members who would need more extensive knowledge that they could then relay to members and volunteers.

In addition to the Public Policy Platform, I included any other downloadable report that details public policy and advocacy issues. These documents included annual reports (2012-2017), as well as reports that address specific topics, such as mental health parity and state legislation. The audiences for these reports were dependent on their scope and the topics they addressed. For example, the annual reports are geared towards many different stakeholders, including staff/board members, donors, and volunteers. Other reports, such as those addressing parity, are directly addressed to lawmakers in order to inform them about problems with current policy and provide recommendations for future policy changes.

I then looked to their news and blogs pages for any posts dealing with advocacy and/or public policy. Their news pages only went back to 2013, so I gathered all relevant posts from that year until June 2019. In total, I collected 130 news posts from their website. Similarly, their blogs only went back to 2012, so I collected posts from that year until June 2019. The total number of blog posts collected for this study was 118. Both the news and blog posts are geared

toward more general audiences, although they seem to be most directly targeting individuals who are already NMHO supporters or members. In terms of other media geared toward their membership, I also included issues of their quarterly magazine, dating back to Winter 2011. In total, I collected 18 issues.

The news and blog posts often included links to letters written to lawmakers as well as written testimony or statements provided to Congress. I downloaded all such links and included them in my collection. In total, there were 16 letters and statements downloaded from links on the website. In addition to these statements, I mined the CSPAN archives for video footage of NMHO advocates testifying in front Congress, as well as footage of televised mental health forums and interviews with CSPAN correspondents. Each video came with a transcript, all which I included in my NMHO document collection.

Finally, since I am an NMHO member, I have access to content placed within a "members only" portal on the website. Through this portal, I gained access to advocacy training materials as well as governance documents that establish the NMHO's mission and goals. All of these materials, which include guides, PowerPoints, one-pagers, bylaws, and articles of incorporation, are all included in the document collection. Lastly, as a member, I received periodic emails with informative memos or calls to action on a particular initiative. I, therefore, included any advocacy email that I received.

Advocacy Materials-NMHO Indiana

For NMHO Indiana, I followed a similar process and also began collecting materials by browsing their website. Much like NMHO National, NMHO Indiana has a page dedicated to their entire public policy platform, as well as individual sub-pages that go more in depth about specific mental health policy issues important to the state of Indiana, including crisis intervention teams and the Healthy Indiana Plan, Indiana's form of Medicaid expansion. NMHO Indiana did not have as many publications or reports to download, but I did include their quarterly newsletter dating back to winter 2014 (14 issues total). I also included any advocacy action emails that I received as a member of their listserv.

Advocacy Materials-NMHO Local

As an affiliate, NMHO Local's top priority is to serve the community through programming such as support groups, presentations, and educational classes. Therefore, while they perform some advocacy work through social media and networking, they produce and disseminate less advocacy materials than NMHO National and NMHO Indiana. Therefore, in my collection of advocacy materials, I only included their advocacy web page, a white paper calling attention to a mental health professional shortage in one of the counties in which they serve and recommending solutions, and 18 issues of their newsletter. The white paper was written by NMHO's former Executive Director, Donna, in collaboration with staff members from two other local nonprofits, and its target audience included Indiana lawmakers as well as staff/board members at other NMHO branches.

Federal Legislation

At the federal level, I included all major pieces of legislation that directly mention mental health care:

- Patient Protection and Affordable Care Act (2010): it is the largest expansion of healthcare coverage since the passage of the Social Security Act in 1965.
- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008): originally signed into law in 2008, but final rules and regulations were published in 2013, and rules and regulations clarifying how the law applies to Medicaid Managed Care Organizations and the Children's Health Insurance Program (CHIP) were published in 2016; this piece of legislation ensures that insurance agencies cover mental health equally to physical health.
- HIPAA Privacy Rule and Sharing Information Related to Mental Health (2014): provides guidance for mental healthcare professionals on sharing necessary medical information with family members/caretakers.
- The 21st Century Cures Act (2016): it incorporated the Helping Families in Mental Health Crisis Act, which is the most significant mental health reform legislation in recent history. The bill includes many different provisions, but the most noted is its strengthening of mental health parity, grants to community mental health programs, and

the establishment of an Assistant Secretary for Mental Health and Substance Abuse Disorders.

- Law Enforcement Mental Health and Wellness Act (2018): it requires the Department of Justice's Office of Community Oriented Policing Services to evaluate and report on mental health services for law enforcement officers.
- National Suicide Hotline Improvement Act (2018): it requires the Federal Communications Commission (FCC) to collaborate with SAMHSA and the VA to study the feasibility of a national suicide and mental health crisis hotline that can be reached by dialing three numbers (similar to 911).
- Sustaining Excellence in Medicaid Act (2019): it extends the Medicaid demonstration program for certified community behavioral health clinics.
- Medicaid Services Investment and Accountability Act (2019): this piece of legislation allows state Medicaid programs to include an option to fund coordinated home care for children "with medically complex conditions," which includes mental health care.

I also chose to include a Supreme Court decision, as these cases often dictate how laws can be applied:

- *Miller v. Alabama* (2012*)*: argued March 20, 2012 and decided June 25, 2012. This case ruled that mandatory sentences of life without parole are unconstitutional for juveniles.

State Legislation

I used the same parameters when seeking Indiana state legislation and collected all new mental health laws from the years 2010-2019 that amended the Indiana Code. All acts passed in Indiana are compiled into one large document each year and are only assigned numbers rather than given formal names. Below, I provide an overview of each of the relevant acts passed from 2010 to 2019.

2010:

- P.L. 11: Allows the Office of Medicaid Policy and Planning to restrict the use of certain psychiatric drugs for individuals under the age of 18; defines the concept "waste" in terms of drug use (overprescribing, underprescribing, patient noncompliance, etc.).

- P.L. 29: Assigns teen suicide prevention to the health finance commission
- P.L. 84: Establishes a license for mental health counselor associates
- P.L. 108: Allows certain courts to offer community treatment and rehabilitation as alternatives to jail or prison for those with a mental illness or substance use disorder.

2011:

- P.L. 127: Prohibits an individual with mental illness from owning a firearm, but allows them to regain this privilege after they have completed treatment
- P.L. 143: Reallocates federal aid to local programs that treat substance use disorders; redefines services provided by community mental health centers
- P.L. 151: Allows for a psychologist, psychiatrist, or physician with the proper expertise to examine a defendant claiming incompetence
- P.L. 160: States that a resident cannot be required to purchase a health plan (in reaction to the Affordable Care Act)
- P.L. 229: Establishes the budget for mental health services

2012:

- P.L. 28: Establishes administrative changes to the Mental Health and Addiction Planning and Advisory Council, the Division of Mental Health and Addiction, and state hospital boards; changes some licensing requirements for therapists and counselors.
- P.L. 48: Establishes an interim study on underserved children with mental health conditions
- P.L. 126: Does not directly affect any mental health institutions, but it does contain stigmatizing language against individuals with mental illness (anyone who has been involuntarily committed to a mental institution is not a “proper person”)
- P.L. 133: Repeals the Mental Health Corrections Quality Advisory Committee
- P.L. 136: Establishes regulations for alcohol/drug services programs

2013:

- P.L. 4: Gives authority to law enforcement officers to detain and transport individuals with a mental illness in crisis to the closest appropriate facility
- P.L. 29: Redefines "professional health care provider"
- P.L. 45: Establishes that an individual living with mental illness is eligible to receive services from the Protection and Advocacy Services Commission
- P.L. 95: Broadens the list of circumstances where a court may assign rehabilitative services in lieu of jail or prison; evaluates funding for a veteran's court
- P.L. 122: Establishes a commission on seclusion and restraints in schools and requires school corporations to adopt restraint and seclusion plans
- P.L. 158: Changes laws concerning drug and alcohol program funding
- P.L. 172: Creates a school safety interim study committee, which must include a mental health professional
- P.L. 185: Establishes new regulations concerning the distribution of controlled substances
- P.L. 188: Requires that the Commission of Mental Health and Addiction perform several studies; changes the term "managed care providers" to "community mental health centers"
- P.L. 204: Requires the Office of Medicaid Policy and Planning to reimburse qualified medical centers, including community mental health centers, for telehealth services
- P.L. 205: Establishes the budget for mental health services

2014:

- P.L. 41: Requires a health care provider to provide a student's mental health information if it is requested by a parent or guardian
- P.L. 54: Designates who can serve as mental health witnesses for an insanity defense
- P.L. 89: Requires the State Department of Health, the Indiana Department of Veterans' Affairs, and the Division of Mental Health Addiction to collaborate on a study about veteran's mental health and substance use disorders; establishes funds for a veterans disability clinic

- P.L. 93: Requires the Secretary of Family and Social Services to study different psychiatric crisis intervention services
- P.L. 113: Repeals certain provisions and funding related to addiction services
- P.L. 131: Tightens regulations for prescribing opioid treatment medications
- P.L. 142: Makes changes to the purpose and functioning of the Mental Health and Addiction Services Development Programs Board
- P.L. 158: Establishes new regulations for community corrections programs; establishes a three-year pilot study in Marion County that aims to reduce recidivism through mental health treatment
- P.L. 164: Requires Indiana Emergency Medical Services to develop protocols for EMS workers to notify law enforcement when they treat someone who has attempted suicide because of bullying
- P.L. 184: States that community corrections programs must utilize evidence-based services, including mental health and addiction services, that will reduce the risk of recidivism

2015:

- P.L. 32: Demands that emergency personnel report to the Department of Health the amount of overdose intervention medication they have administered
- P.L. 115: Requires all law enforcement training to include crisis intervention team training
- P.L. 154: Requires Medicaid to cover inpatient substance use detoxification services
- P.L. 179: Allows the Division of Mental Health and Addiction to use grant funds for mental health and addiction forensic treatment programs
- P.L. 185: Establishes new regulations for community mental health centers; mandates that the Division Mental Health and Addiction develop a mental health first aid training program; establishes new regulations for mental health in schools
- P.L. 187: Gives a prosecuting attorney the authority to require an individual in jail diversion program to participate in mental health treatment

- P.L. 209: Establishes regulations for addiction treatment plans, particularly those that use methadone and other detoxification drugs; states that they must be run by the proper treatment programs, which include community mental health centers
- P.L. 213: Establishes funding for mental health services

2016:

- P.L. 6: Establishes more regulations concerning overdose intervention drugs
- P.L. 7: Establishes the Indiana Commission to Combat Drug Abuse
- P.L. 8: Requires that Medicaid cover inpatient detoxification treatment for opioid and alcohol dependence
- P.L. 19: Mandates that state employee health plans allow individuals to request an exception to step therapy protocols for prescription medications
- P.L. 30: Revises the Healthy Indiana Plan
- P.L. 37: Prohibits Medicaid from covering Subutex, Suboxone, or other similar generic drugs if it was prescribed for pain management or addiction treatment; mandates the Division of Mental Health and Addiction develop best practices for treating opioid dependence.
- P.L. 44: States that an individual participating in a syringe exchange does not establish probable cause or reasonable suspicion
- P.L. 78: Establishes regulations for telemedicine services, such as rules about prescribing certain medication
- P.L. 69: Allows the Department of Corrections to award grants to county jails that would allow them to provide mental health and addiction forensic treatment services
- P.L. 87: Adds to the different types of mental health professionals who are eligible be reimbursed by Medicaid
- P.L. 108: States that the Indiana Veterans' Affairs commission must submit an annual report on the welfare of veterans

2017:

- P.L. 102: Gives the Law Enforcement Training Board more oversight over crisis intervention team training
- P.L. 125: Establishes a three-year opioid addiction treatment pilot program in Tippecanoe, Marion, and Wayne counties
- P.L. 150: Mandates that Medicaid reimburse all providers who are eligible to provide telemedicine services
- P.L. 165: Establishes additional reporting requirements for opioid treatment programs; requires the Office of the Secretary of Family and Social Services to collaborate with the State Department of Health and the Department of Administration to develop a plan to increase the number of inpatient beds used for substance use treatment
- P.L. 168: Begins a pilot program that would reimburse physicians who get medication assisted treatment training
- P.L. 172: Establishes new standards for recovery residences for individuals with chronic addiction
- P.L. 174: Establishes a pilot program to help pregnant and postpartum women with opioid addiction recovery
- P.L. 175: Allows for a substance use pilot program in Allen County
- P.L. 203: Provides guidelines for addiction treatment teams
- P.L. 205: Adds new members to the Commission to Combat Drug Abuse
- P.L. 217: Establishes the budget for mental health services
- P.L. 243: Provides guidance on residential care and supported housing for chronic addiction, as well as child welfare substance use treatment services
- P.L. 254: Requires school corporations to provide suicide awareness and prevention training to students every three years starting in the 5th grade

2018:

- P.L. 4: Allows for community corrections officers and probation officers to administer overdose intervention drugs

- P.L. 56: Designates responsibility to the Division of Mental Health and Addiction for overseeing suicide prevention training for health care providers
- P.L 68: Suggests a committee to study pharmacy deserts in rural and urban areas
- P.L. 76: Specifies funding streams and amounts for community mental health centers
- P.L. 160: Establishes new licensure guidelines for clinical social workers, mental health counselors, and marriage and family therapists
- P.L. 195: Strives to increase mental health access through a number of measures, such as through the approval of nine additional opioid treatment programs
- P.L. 202: Suggests a study to convert some underused or unused facilities at a state hospital to spaces for substance use treatment programs
- P.L. 209: States that an individual who violates probation, parole, community corrections, a reentry court program will not be allowed to receive Supplemental Nutrition Assistance Program (SNAP) benefits

2019:

- P.L. 22: Establishes a committee to study the pricing of prescription drugs
- P.L. 49: Establishes new regulations for licensed mental health professionals
- P.L. 96: Allows the Division of Mental Health to develop community and faith-based substance use grants
- P.L. 100: Establishes guidelines for mobile integrated healthcare, which facilitates coordinated care amongst various health professionals, like emergency medical care providers (EMS), hospitals/medical facilities, and insurance companies
- P.L. 108: Establishes funding for mental health services
- P.L. 128: Mandates that Medicaid consider licensed clinical social workers, licensed mental health counselors, licensed clinical addiction counselors, and licensed marriage and family therapists eligible providers of outpatient mental health or substance use treatments
- P.L. 130: Allows for telepsychology and establishes some guidelines
- P.L. 145: Establishes grants for comprehensive addiction recovery centers

- P.L. 153: Allows for schools to use grants from the Secured School Fund for mental health initiatives
- P.L. 179: Requires Medicaid to cover inpatient detoxification when it is medically necessary
- P.L. 213: Establishes regulations for office based opioid treatment providers
- P.L. 222: Extends the opioid treatment pilot program until 2022
- P.L. 225: Mandates that the Division of Mental Health and Addiction establish a standard format for individualized mental health safety plans; establishes several other guidelines related to mental health safety plans
- P.L. 289: States that an individual deemed dangerous cannot own or possess a firearm

Local Legislation

The local legislation included in this study was produced by the Tippecanoe County Council and the Tippecanoe County Health Department. The NMHO local affiliate represented in this study serves a total of eight counties, but their office is located in Tippecanoe County (which also has the largest population of all eight counties). Therefore, due to time constraints, I chose to only include legislation from their "home base" and from the county where they serve the most people. I included four resolutions that were passed between the years 2015-2018. They were all yearly resolutions reconfirming funding for community mental health centers in the county.

3.3.6 Phase 2: Interviews

Recruitment

After collecting all the necessary documents and obtaining IRB approval, I solicited interview participants by emailing NMHO staff members directly. As per my IRB protocol, I prepared a message that briefly detailed the project and explained their role as a participant. I also attached the informed consent form so that they understood their role in the project as well as the risks and benefits to participating, in addition to the questions that I would ask during the interview. I wanted them to be prepared and to give them the opportunity to say no if they did not feel confident or comfortable answering any of the questions. If they agreed to participate,

we arranged a date and time to either meet in person or talk over the phone. If we met in person, I brought copies of the consent form for them to sign before we officially began the interview. If the interview took place over the phone, I asked them to digitally sign the consent form and send it back to me before the start of the interview.

Inclusion Criteria and Description of Interviewees

The inclusion criteria for participants in this study are staff members at NMHO National, NMHO Indiana, and NMHO Local who work with public policy and/or advocacy, as well as individuals who have knowledge of how the different levels of NMHO interact. While I contacted 12 individuals, only 8 agreed to participate:

- At NMHO National
  - "April"—Senior Manager, Field Advocacy. April is in charge of the national office's advocacy communications, which include blogs, news, social media, and memos.
  - "Ben"—Director of Legislative and Policy Advocacy. Ben manages the organization's federal policy agenda and communicates with members of Congress and other federal agencies.
- At NMHO Indiana
  - "Leslie"—Programs Director. Leslie oversees NMHO Indiana's programs that are offered through their local affiliates and provides training for volunteers.
  - "Ann"—Criminal Justice Director. Ann provides support to communities in Indiana who want to implement crisis intervention services, and she works with criminal justice policy.
  - "Gabrielle"—Communications & Policy Director (now Executive Director). As the Communications & Policy Director, Gabrielle tracked mental health public policy and legislation at both the state and federal level, and she performed outreach with the organization's stakeholders, including Indiana state legislators.
- At NMHO Local
  - "Lucinda"—Executive Director. Lucinda is in charge of community engagement to help build NMHO's programming and partnerships with other agencies. She oversees all of NHMO Local's daily operations and finances.

- "Donna"—Former Executive Director. Donna as the former Executive Director performed the same duties as Lucinda.
- "Rita"—Program Coordinator. Rita also oversees daily operations, including programming and membership. She also provides resources and guidance to anyone who calls or visits the office seeking information on mental health services in the community.

The demographics of these individuals vary in terms of gender, age, and ethnicity, but they are all over 18 and were able to consent to participation. I will not provide any specific demographic information in order to preserve confidentiality.

One aspect of NMHO's organizational structure is that they pride themselves on involving individuals who have experienced a mental health condition directly or indirectly, meaning that some staff members may be in recovery from mental illness or have family members who have a mental illness. Unless an interviewee disclosed this information to me, I did not know their relationship to mental illness, and I did not ask about their personal experiences. For privacy reasons, any voluntary disclosure of a mental illness by an interviewee is not included in the write-up of this study.

Interview Questions

I asked all eight interviewees the same questions, with some adjustments depending on the level of the organization and the answers provided by each individual (see Appendix C for original interview form):

- Do you work for NHMO National, NMHO Indiana, or NMHO Local?
- Describe your role at NMHO. What is the title of your position, and what do you do on a day-to-day basis?
- What types of documents do you write or work with regularly? Describe how you use these documents and how they impact your role at NMHO.
- [For staff members at NMHO Local] How do you use materials produced by NMHO at the national or state level?
- Has any of NMHO Local's initiatives impacted NMHO at the national or state level?

- How would you describe the impact that state and/or federal legislation have on NMHO's mission and goals?
- How would you describe the impact that state and/or federal legislation have on the types of writing/documents that NMHO produces?
- How would you describe the impact that state and/or federal legislation have on mental health issues in local communities?
- What is your relationship to state and/or federal lawmakers? How often do you interact with them?
- What is your perception of NMHO's impact on mental health?

Interview Transcription and Storage

As stated previously, the audio of each interview was recorded with QuickTime and then subsequently stored in a password-protected folder on my personal computer. I then transcribed all interviews for data analysis in NVivo. I will note that my transcriptions are not perfect and do not capture interviewees' vocal nuances (e.g., I did not record vocal fillers) because I was not concerned with *how* they spoke but rather *what* they spoke about. I was more interested in the content of their responses instead of any linguistic or extra-linguistic features in their speech.

3.3.7 Phase 3: Assemblage Mapping

Stakeholders/Components and Communication Channels

Before I began analyzing the interviews and documents, I created assemblage maps of the stakeholders involved in my project, following the guidelines Angeli (2017). One map focuses on the communication channels among the stakeholders/components, and the other focuses on power dynamics. These maps appear in Chapter 4 within the Major Finding 1 section.

The first step in creating these maps was to brainstorm the list of components (stakeholders, values, and communication channels) that make up the study by turning the following three questions into columns in a table:

- Whom does my project involve? (stakeholders): For this project, the stakeholders include me as a researcher/volunteer, NMHO National, NMHO Indiana, NMNHO Local, the staff and volunteers at all three levels, the authors of the documents in this dataset,

federal and Indiana state legislators, health insurance companies, individuals living with mental illness and their family members who are affected by the effects of advocacy and legislation, and the university IRB.

- What will the stakeholder value? (values): A stakeholder's values include their concerns and priorities related to the project and to their work. For example, NMHO staff and volunteers will value the respect and privacy of those who use their services.
- How can I communicate with the stakeholder? (communication channels): Communication channels include email, phone, face-to-face, video chat, or indirect communication through other stakeholders.

I note that I did not, in most cases, note the actual type of communication channel that was used among components; instead I simply identified that there was some form of communication among them and whether that communication was reciprocal or not. I made this decision because I am not taking into account communication technologies such as email or telephones as components within the assemblage (although future studies could certainly include them).

Power Dynamics

Next, I created a "power dynamics table" with two columns: one with "The Project's Stakeholders" and another with the question, "What power dynamics do I need to be aware of? How are we similar and different?" Examples of potential power dynamics include gender, race, education level, socioeconomic status, age, and influence. However, in the case of my project, I primarily focused on influence. Then, based on the two tables, I answered the questions, "Which stakeholders interact and communicate with one another, and how?"; "What values do stakeholders share?; "How are stakeholders connected?" Finally, I created two separate maps—one demonstrating the communication channels among stakeholders and another showing the power dynamics. Stakeholders were arranged on the page based on their level of power dynamics as well as similar priorities/values. Lastly, these groups of stakeholders were linked together by arrows to indicate the communication channels or how power flows throughout the assemblage.

I performed assemblage mapping as my first step because, since my study requires me to work with different levels of the organization, it was important for me to anticipate how those power dynamics might affect my research. Furthermore, as both a volunteer for the organization

and a researcher, I must be aware of the unique role that I have in the organization and the power dynamics that stem from my position at the university. At the end of this process, I produced two assemblage maps that demonstrate the connections among federal and state governing bodies, the different levels of the NMHO, and myself as a volunteer-researcher. These connections also illuminate how documents and communication circulate throughout the assemblage.

3.3.8 Phase 4: Coding and Data Analysis

Next, I coded both the documents and the interview transcripts to determine how legislation and advocacy initiatives interact and how the local, state, and national levels influence each other. To develop my codes, I used grounded theory, "a qualitative strategy in which the researcher derives a general, abstract theory of a process, action, or interaction grounded in the views" gathered from participants and data collected in the study (Creswell, 2008, p. 229). Grounded theory involves three stages: coding, integration, and dimensionalization.

In the first stage, the researcher codes "as many categories as possible from the data" based on their "own lived experiences in the scene" (Lindlof & Taylor, 2002, pp. 218-219). During this stage, Lindlof & Taylor (2002) also recommend that researchers write themselves "theoretical memos" that "flesh out the thematic qualities of the coding categories (p. 220). Then, during the integration stage, researchers "make connections between categories," thereby creating "new categories or a theme that spans many categories" (p. 220). Finally, during dimensionalization, the researcher defines characteristics or "dimensions" of categories and, in the process, eliminates some categories to make the data set more manageable (p. 222). I chose to use grounded theory for this step in my research process for several reasons. First, it is a commonly used analysis method in RHM. Second, before analyzing the documents and conducting interviews with my participants, it was difficult to anticipate the types of connections that existed between the documents and the different levels of the organization. Finally, I did not want to run the risk of assigning categories and falling into the trap of confirmation bias, as the connections should emerge from the findings and not from my own expectations.

Step 1: Attribute Coding

I used NVivo to code all my documents. NVivo allows researchers to assign attributes (meta-data) to each piece of data and develop "nodes" (codes) that store excerpts of text, images, audio, and video so that they can discover patterns and themes. Before I began coding for themes and content, I first performed attribute coding, which is a "data management technique" that involves tagging documents with basic descriptive information, such as format/genre, date, etc. (Saldaña, 2016, p. 73). For each document, I assigned the attributes audience(s), author or speaker, genre, and year of publication. I note the intended audience(s) because their "destination" may help to determine the "flows" or "lines of flight" they take within the assemblage. And while the author or speaker is not clear for all the documents (for example, many NMHO documents are only attributed to the organization, not to individual authors), I decided to record this information in case any particular individuals seemed to stand out and establish themselves as a significant component to the assemblage. Then, in terms of genre, I wanted to keep in mind the "concrete" aspect of the assemblage, and genres, even when they're digital, have real, material characteristics. Finally, I chose to tag the year of publication because, although assemblages are not linear, they are still "deliberate and purposeful" (Buchanen, 2015) and driven by "social and historical processes" (Nail, 2017). Therefore, keeping track of the year of publication will show how these documents interact within the historical development of the assemblage.

Step 2: Exploratory Coding

After assigning the appropriate attributes to each document, I began the first phase of coding. According to Saldaña (2016), the first round of coding should be more exploratory and include methods such as structural or holistic coding (for a "grand tour overview" of the data); descriptive coding to help researchers take a "detailed inventory" of the content covered in their data; and in vivo, process, and/or values coding any interview transcripts in order to "[attune themselves] to participant perspectives and actions" (p. 73). For this initial round of coding, I did a combination of holistic, descriptive, and process coding. Holistic coding can be thought of as "macro-level coding" because it involves sorting documents into nodes based on basic themes of issues that emerge in the data (Saldaña, 2016, p. 166). This type of coding does not involve

going through a document line-by-line; rather, the entire document gets assigned to categories for the researcher to return to later. My holistic coding blended with my descriptive coding, which involves assigning codes based on content. As I started sorting documents, I tended to assign codes based on the topics that were discussed in the documents. For example, the NMHO has several reports and many news articles and blogs that address parity, so all those documents were assigned to a "parity" node. However, I wanted to discover patterns that covered more than just the content in the documents; I also needed to know how the data produced action—how it created flows and lines of flight that effected change within the collection of documents, within the organization, and within the mental health care system. Therefore, I also used process coding, which "uses gerunds ('-ing' words) exclusively to connote action in the data" (Saldaña, 2016, p. 111). As an example, I noticed that many documents discussed funding in some manner, so two of my process codes were "increasing funding" and "decreasing funding."

I chose to code the interview transcripts first because I asked participants more general questions about the different levels of the NMHO and their involvement in advocacy initiatives. Their responses guided me toward particular topics, such as funding for mental health care and collaboration with other agencies, that may potentially become common themes across all the documents. Then, although I did not necessarily want to use a linear progression to code my materials, I decided to code NMHO documents and legislation according to the year that they were published. I began with all documents published in the year 2010 and concluded with all documents published in the year 2019. As stated previously, I began by assigning codes to entire documents first and then performing line-by-line coding. I did not confine myself to a particular unit of analysis because in some instances an entire paragraph covered the same theme or topic and in others the theme or topic varied by sentence. I will admit that this choice is unorthodox, but I believe that it fits with Assemblage Theory as a framework. Being unconfined from a particular unit of analysis allows my writing and analysis to "fly off in all directions" (Deleuze, 1995) and demonstrates how anything from a single phrase to an entire document could potentially territorialise or deterritorialise within the assemblage.

I also add that, during this process, I followed some similar steps/principles to Augustine (2014), who describes her choice to not code for her dissertation and instead use the concept of assemblage to analyze her data. Although I did in fact code my interviews and the documents I

compiled, I also relied heavily on "writing my way through" the interview transcripts and documents as I noticed patterns and themes emerging (Augustine, 2014, p. 749).

Step 3: Integration and Dimensionalization

Following this exploratory coding, I moved into the integration and dimensionalization stages of grounded theory. I talk about them in tandem because I found that I could not easily separate combining codes and eliminating them into two separate steps. One simple way that I eliminated codes was in terms of the frequency that they occurred. Any nodes that contained significantly less excerpts of texts than others were eliminated. For instance, I initially had a code for elderly mental health care, but that topic only reoccurred in several places throughout the entire dataset, so I removed it. Additionally, I combine related codes into subcodes of a larger theme or topic. For example, "increasing funding," "decreasing funding," and "developing a new form of funding" all discuss funding in some form, so they were converted into subcodes under the umbrella term "providing funding." I also used the analytical writing I did during Step 2 to help me during this phase.

Once I finalized the codes, I used the crosstab query function in NVivo to discover patterns across the interview transcripts and documents. This function enables researchers to see how codes develop across various attributes assigned to the documents, such as year of publication and genre. Because my main goal was to demonstrate how advocacy initiatives and legislation develop and affect each other over a certain time period, I primarily used year of publication as a way to discover patterns and themes in these queries. Then, I went back to the individual materials to find particular connections that exemplified these patterns.

Step 4: Data Analysis Using Rhetorical Ecologies and Assemblage Theory

I then analyzed the themes, patterns, and connections within the collection of documents and the interview transcripts using assemblage theory as the frame for my criteria. Specifically, I used the concepts of affective flow, territorialisation, and deterritorialisation to determine how the documents and the different levels within the organization interact as an assemblage within the broader healthcare system (Fox & Alldred, 2015).

For this project, I considered an affective flow to be any type of action or interaction that produces change within the organization or within mental health legislation. I characterized the affective flows of each document and each level of the organization as either aggregative or singular:

- An aggregative flow constituted an action or interaction that produces change across documents or across levels of the organization.
- A singular flow, on other hand, constituted an action or interaction that produces change that affects only one document or one level of the organization.

Then, I determined if the affective flow has territorialised or deterritorialised the NMHO or mental health legislation:

- An affective flow territorialises if it attempts to produce order within the organization or within mental health legislation, e.g., it attempts to standardize programs or processes across the organization, or it attempts to standardize mental health care.
- An affective flow deterritorialises if it goes against the order or the "status quo" of the organization or current mental health legislation, e.g., it creates new programs or proposes a more individualized approach to mental health care.

At the end of this analytical process, I was able to generate a rich description that includes specific examples of how the documents have affected mental health legislation and the different levels of organizations. I did not use any statistical analysis software and instead relied on the patterns identified through NVivo's analytical functions that I described in the previous section. In Chapter 4, I identify several broad trends across the dataset and then use specific examples to demonstrate these patterns.

3.3.9 Limitations

As with any academic study, my research has some limitations. First, my participant pool is small. Both NMHO Indiana and NMHO Local have a relatively small staff, and only several NMHO National employees responded to my request for an interview. I also only included one local affiliate, while there are 13 total in the state of Indiana and more than 500 nationally. Moreover, I was not able to gain access to all the internal communications between the levels of the organization, and I was only able to include a few letters/reports directed at legislators in the dataset. I did not have any access to personal communications between NMHO staff and

lawmakers, although several members who participated discussed their experiences communicating with legislative officials. Furthermore, while I have over 400 NMHO documents and 24 legislative documents included in my dataset, the amount of information I have compiled is still limited. As I mentioned in the introduction to this chapter, the NMHO advocates for legislation/policies related to homelessness, food insecurity, and other issues beyond mental health itself. Due to time and technological constraints, I limited the legislation in this dataset to that which specifically addresses mental health/health care issues. Therefore, my study provides a limited glimpse into the NMHO, the viewpoints of its staff members, and the legislative initiatives that affect mental health outcomes. Additionally, since I only collected advocacy materials from one organization, I am not able to generalize my findings to other similar organizations.

Second, as I mentioned previously, I did not use a particular unit of analysis (e.g. phrase, sentence, paragraph) when I assigned my codes. So, in some cases, one sentence would be assigned a code, and, in other instances, an entire paragraph. I will also add that, no matter if I was coding an entire document, paragraph, or sentence, I often found it difficult to assign one code to each unit of analysis. For example, I noted many instances where the speaker or author mentioned homelessness, health insurance, and criminal justice all in the same sentence. I did not want to code individual words/phrases because the surrounding context is important to understanding how the documents interact. Therefore, I assigned a number of simultaneous or overlapping codes (Saldaña, 2016, pp. 94-97). Although some may interpret simultaneous coding as a sign of a researcher's "indecisiveness," in my case, I consider it to be a strength as it reveals the complexity surrounding mental health care advocacy and legislation.

Third, since I used NVivo for my coding and data analysis, how I interpreted my data was limited by the capabilities of the software. For example, when you assign a code to a document or any other piece of media, NVivo records the number of files that contain that code, as well as the number of times that code is assigned both within a single document and across all documents in the dataset. Because I did not use a set unit of analysis for my codes, I could not use the frequency at which the code appears across documents to demonstrate patterns within the dataset. Instead, the crosstab queries, which I referenced in the previous section, allowed me to see the number of documents in which the code appeared, or the prevalence of a code in terms of the percentage of coverage across documents. This percentage is calculated based on the number

of characters within a document or throughout a set of documents or the entire dataset. This strategy might not be the typical way that a researcher demonstrates patterns through qualitative coding. Therefore, readers may question this method of calculation and its significance.

Finally, I will admit that my own technical/design skills limited the ways in which I was able to visually demonstrate the interactions among the components in this assemblage. As my readers will see in Chapter 4, the maps that I generated admittedly look hierarchal, as all the national/federal components are at the "top" of the assemblage while the local levels are at the "bottom." I attempted to mitigate this with the use of bidirectional arrows that indicate open communication channels among the different levels of the components (and thereby demonstrate opportunities for the state and local to influence the national/federal); however, the static maps that I produced still do not quite capture the constant ebb and flow of an assemblage. Therefore, in addition to the maps, I rely on heavy description of the interactions that my analysis revealed.

3.4 Conclusion

In this chapter I have presented my theoretical framework, which largely draws from Assemblage Theory as well as Rhetorical Ecologies, Material Rhetorics, and Institutional/Organizational Theory. For this project, which examines the relationship between legislative documents and advocacy materials, I rely on a definition of rhetoric where language and discourse produce material effects as a result of constant circulation across distributed elements. I contend that Assemblage Theory is a productive framework for understanding how legislative documents and advocacy materials interact and circulate within the United States mental healthcare system because it provides terminology for what occurs as discursive and material components interact. Furthermore, it enables researchers to demonstrate how both the assemblage as a whole and the various components are affected as a result of these interactions. Ultimately, I use Assemblage Theory to analyze the data that I collect as a result of my case study with the NMHO. I have presented the methods used to conduct this case study and demonstrated the steps I used to generate my results, which I will present in Chapter 4. In this chapter, I will articulate my major findings based on the research questions that I first introduced in Chapter 1. Then, in Chapter 5, I use Rhetorical Ecologies, materialism, and Assemblage Theory to illustrate what the connections or "flows" among the components in this study reveal

about mental health advocacy and legislation as rhetorical assemblages that have material effects on mental health care in the United States.

CHAPTER 4: RESULTS

4.1 Introduction

As a volunteer and a researcher, I became more intimately acquainted with the innerworkings of the National Mental Health Organization (NMHO) and how communication circulates within and outside the organization. While advocacy is not the NMHO's sole purpose, it is a significant part of their mission, and many of the materials and media distributed both internally and externally focus on mental health legislation and policy. These materials take the form of a variety of genres and are often targeted toward multiple audiences, which means that the NMHO must use a coordinated strategy to ensure that it is responding appropriately to external influences and sending a consistent message to all stakeholders at the national, state, and local levels. Thus, the findings presented in this chapter illustrate how advocacy initiatives emerge within an organization, how legislative documents affect those initiatives, and, in turn, how those initiatives impact legislation. In order to present those findings, this chapter answers the following research questions that were first introduced in Chapter 1:

- How do the different levels of mental health legislation and the different levels of a mental health advocacy organization interact and influence each other?
- How does federal, state, and local legislation impact the advocacy materials produced by mental health advocacy organizations?
- How do advocacy materials produced by mental health advocacy organizations attempt to impact federal, state, and local legislation?
- How do advocacy materials and legislation impact the United States mental health system at the federal, state, and local levels?

The subsequent sections are organized as responses to each of these questions, and each section title represents a finding that answers one of the research questions presented above. Each section also includes subsections that break down the major findings into more specific points that provide evidence for each finding. The four major findings are as follows:

1. Components at the federal/national level have more power and, therefore, produce more significant effects than other components at key moments as mental health issues fluctuate and evolve over time. In this study, power was measured based on the influence

that these stakeholders/components had on other components within the assemblage. My study found that power primarily flows from the national/federal level to the state and local. Additionally, NMHO advocacy initiatives have the most impact on the corresponding levels of legislation. However, the state and local levels have the ability to produce affects beyond their levels, particularly within NMHO, as the organization has free flowing, open communication channels among the various levels.

2. NMHO's advocacy materials are often reactions to legislation and other policy initiatives, as the topics most commonly discussed within the NMHO's advocacy materials reflect the topics that get addressed within the legislative documents. Additionally, I found that the purpose of a significant portion of the advocacy materials was to either support or condemn legislative acts as they were introduced or passed.
3. NMHO's advocacy materials impact legislation through direct communication to lawmakers as well as indirect communication from members. The materials targeted directly to lawmakers were most often persuading them to support an initiative or act in a particular way when certain bills were up for a vote. The materials targeted to members and the general public that aimed to impact legislation were those that compelled individuals to contact their legislators or voice support for an initiative in some other form.
4. Advocacy materials and legislative documents have material effects on the mental health system in the United States. In terms of advocacy materials, their language is meant to induce actions that put pressure on lawmakers to improve mental health legislation and policy. In terms of legislation, there are different categories of language that generate various actions that then have material effects on the mental health system, such as defining who is or isn't eligible to receive resources and designating funding to particular programs.

The findings in this study are based on a combination of interviews and a qualitative coding analysis of mental health legislation and various genres of advocacy materials produced by the NMHO. Ultimately, the findings suggest that the interaction of language amongst the different levels of mental health legislation and mental health advocacy organizations have material effects on the mental health system in the United States.

4.2 Findings

4.2.1 Major Finding 1: Power primarily flows from federal/national to state and local

Both the NMHO and the United States government are structured similarly in that they have federal/national, state, and local levels. On the surface, this structure is hierarchal since there is a clear delineation between the different levels, and the federal/national level is at the "top" and ostensibly governs everything below it. However, the NMHO identifies itself as a grassroots organization, meaning that they rely on collective action from individuals all the way down to the local level in order to effectively advocate for change. Similarly, while the federal government has wide-ranging authority in the United States, the Tenth Amendment of the U.S. Constitution grants certain powers not held by the federal government to state and local governments (U.S. Const. amend. X). So, while the NMHO and the United States government may in some ways function hierarchically, there is more complexity behind how their various components and levels interact.

Therefore, the first question my study seeks to answer is "How do the different levels of mental health legislation and the different levels of a mental health advocacy organization interact and influence each other?" To answer that question, after compiling all the documents in the dataset and recruiting interviewees, I first created assemblage maps that demonstrated how values/priorities, communication channels, and power dynamics affected the stakeholders/components of this project. These assemblage maps (see Figure 1 and Figure 2) show that while the different levels of legislation and a mental health advocacy organization may overlap in values and interact in a variety of ways, influence and power primarily flow from national/federal to state and local, or in a horizontal direction among NMHO National and federal legislation, NMHO Indiana and state legislation, and NMHO Local and local legislation. However, as I will demonstrate later in this section, the state and local levels have the ability to exert power and effect change across levels within the assemblage. The purpose of creating these maps was to demonstrate the connections that exist amongst the components in the legislative-advocacy assemblage presented in this study. These connections illuminate how interactions between legislation and advocacy materials have rhetorical effects on the mental health system as they circulate through the assemblage.

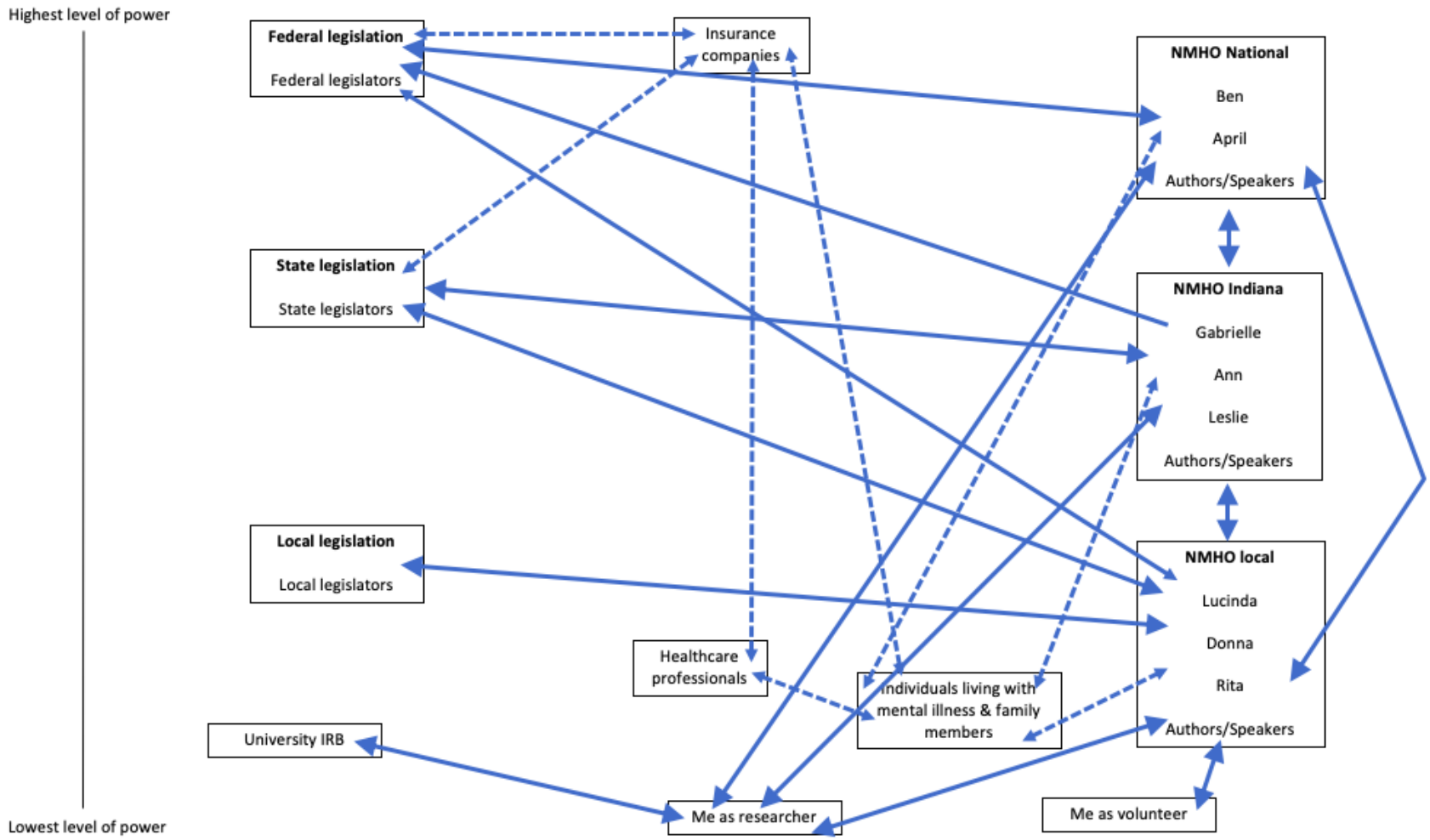

Figure 1: Communication channels among stakeholders/components

In Figure 1, the placement of each stakeholder/component was determined based on their values/priorities and the power dynamics between them. Stakeholders/components were grouped or placed within close proximity of each other when they shared common values/priorities. Stakeholders/components that hold the greatest power were placed closer to the top of the assemblage while stakeholders/components with the least power were placed closer to the bottom of the assemblage. The arrows indicate a communication channel among the various stakeholders/components. A bidirectional arrow indicates that there is reciprocal communication between the two stakeholders/components. A unidirectional arrow indicates that communication only flows in one direction, with no or minimal response or initiated dialogue from the receiving stakeholder/component. Additionally, dotted lines are used with stakeholders/components that are not objects of study within this dissertation but are nonetheless a part of this assemblage and affected by the NMHO's advocacy materials and/or legislation in this dataset.

I began by grouping each component according to common values. Since they are one unified organization, each level of the NMHO generally holds the same values: enacting the organization's mission, receiving funding, advocating for people with mental illness and their family members, bolstering the organization's reputation, and educating people about mental health. Any slight differences in values stemmed from the specific role of each level: NMHO National must communicate with federal officials and support the state organizations and local affiliates, NMHO Indiana must communicate with state officials and support all the local affiliates in the state, and NMHO Local must run all programming. Additionally, since all interview participants are former or current staff members at NMHO, they are grouped with the level where they work.

Federal, state, and local legislation, along with the legislators who write and approve of the legislation, are also grouped together because, despite their lack of communication between levels, they also have similar values/priorities: getting elected and staying in office, serving their constituents, passing bills, improving mental health outcomes, setting rules and regulations, and directing funds.

As mentioned previously, in the map I also included groups of stakeholders who aren't necessarily participants or "objects" of study but who are involved or could be affected in some way by this project. First, I have separated the two aspects of my identity in relation to this project: me as a researcher and me as a volunteer. Although it's not possible to completely take

off my researcher hat as I'm volunteering, I still see them as two separate roles because, beyond the newsletter that I edit, design, and write for each month, I do not include in the dataset for this project any other materials that I work with or anything that I learn or overhear while I am working as a volunteer. Additionally, my values/priorities as a researcher are much different than my priorities as a volunteer. As a researcher, I am most concerned with completing the project, producing new knowledge, conducting ethical research, and learning something new about mental health legislation and advocacy. Quite differently, as a volunteer, I am most concerned with supporting the organization's mission, circulating their monthly newsletter, and serving my own personal interests and stake in the mental health conversation. My values/priorities as a volunteer are much more closely aligned to NMHO, so I have placed that aspect of my identity closer to those components. My identity as a researcher is the closest to another stakeholder in this project: the university IRB. The IRB's main values/priorities are to ensure that my research is ethical so that no human subjects involved in my project experience harm and that my research complies with all government regulations and standards (Office of Research Administration, 2008). The IRB is much more distant from the rest of the components in the assemblage map, but it does play an important, regulatory role within the project.

The other stakeholders included in the assemblage map are the authors/speakers in the dataset, individuals living with mental illness, family members and friends of those with a mental illness, mental health professionals, and insurance companies. I include these groups because they are either represented in the dataset in some manner, or they are affected by the materials or those who created the materials. The authors/speakers are anyone who composed an NMHO advocacy material. They are serving as representatives of the organization; therefore, I consider them to have the same values and have grouped them with the different levels of the NMHO and the interview participants. Individuals living with mental illness and their family members/friends want better treatment and care, support, recovery, and understanding about their experiences. Mental health professionals would also like better treatment and care for their patients, more resources and support for their work, and better working conditions with less burnout. These three groups are placed together because they also have similar values/priorities. Insurance companies, on the other hand, do want to manage patient care and treatment, but they also want to make a profit. They are placed closer to the top of the assemblage because they are a powerful lobby that often influences legislation at all three levels.

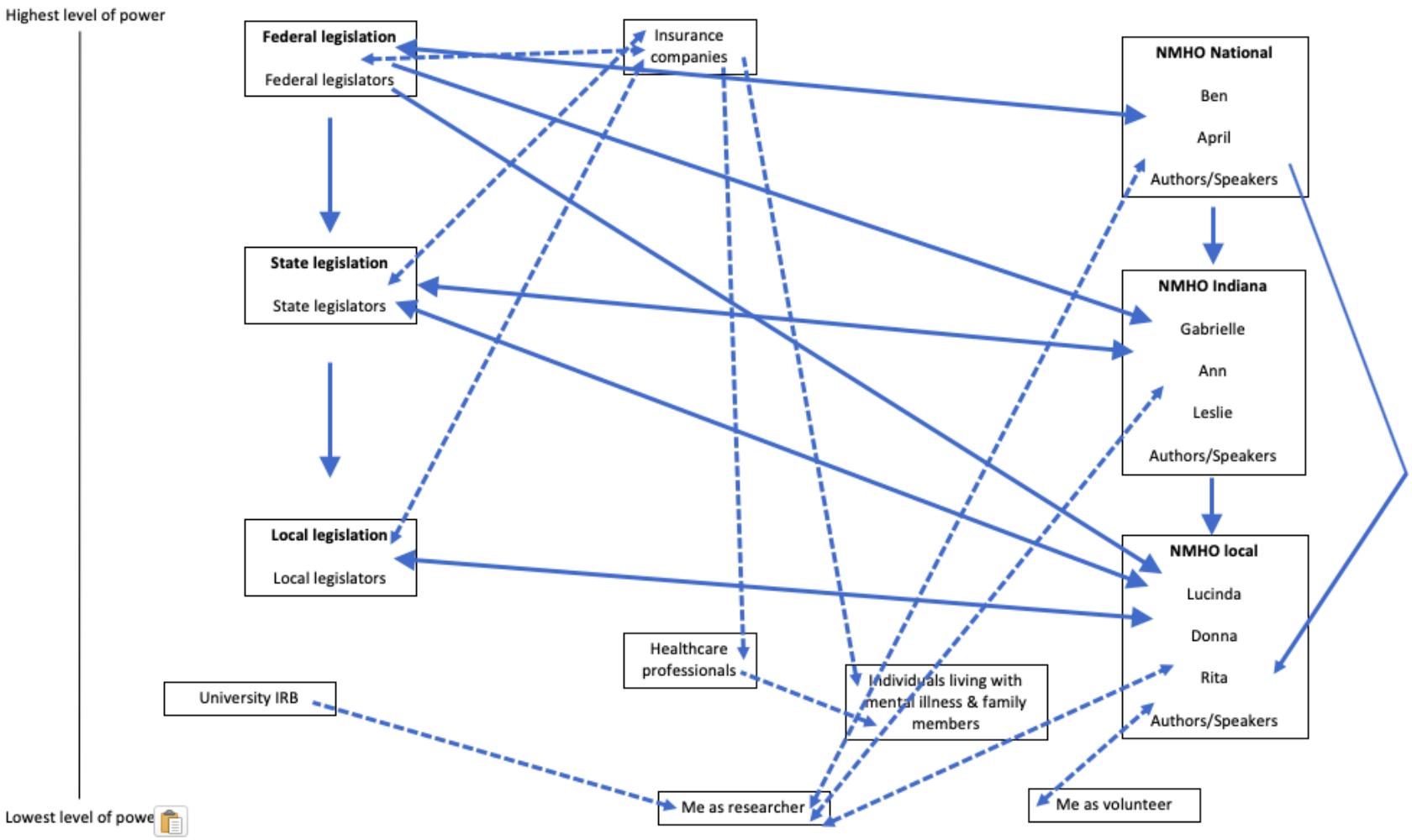

Figure 2: The flow of power among stakeholders/components

I then created a second assemblage map (see Figure 2) to demonstrate the flow of power among the various stakeholders/components. As in Figure 1, the stakeholders/components are arranged according to their common values/priorities as well as their power dynamics. However, in this map, the direction of the arrow signifies the direction of power. I use the following subsections to expound on the communication channels and power dynamics illustrated in these maps and demonstrate how my findings support them.

NMHO has shared values/priorities and free-flowing communication, but power/influence is most concentrated at the national level and flows to state and local.

Although the NMHO has different levels—as well as hundreds of state and local affiliates spread across the United States—it is still one, united organization committed to the same values/priorities. This fact is demonstrated through the mission statements published on the NMHO National, NMHO Indiana, and NMHO Local websites:

- NMHO National mission: advocacy, education, support, and awareness to improve the lives of individuals living with a mental illness
- NMHO Indiana: improving the lives of individuals living with a mental illness, along with their family and friends; supporting local affiliates by training volunteers; offering continued education for mental health professions; affecting systemic change at the state level
- NMHO Local: advocating for effective treatment and education for individuals living with a mental illness and their family members[3]

While each level might serve different purposes or perform different tasks/actions (for example, only NMHO Indiana claims to train volunteers), all three of these mission statements revolve around advocating for and supporting individuals with mental illness and their family members. Furthermore, the NMHO describes itself as a grassroots organization which as Gabrielle, former Communications & Policy Director and current Executive Director of NMHO Indiana, says, means that "it is really the people at the affiliate level who are doing the work" while the national and state levels provide materials and support (Personal communication, October 29, 2018). In fact, according to April, Senior Field Manager of Advocacy at NMHO National, the local

[3] These mission statements have been paraphrased so that they can't be easily traced back to the organization.

affiliates existed before the national and state organizations (Personal communication, November 9, 2018). They are the ones who originally created—and are currently running—all of the organization's support groups and working in the communities.

Because of this shared mission and their grassroots structure, the lines of communication are fairly open among the different levels, and there are a variety of ways for national, state and local to interact. For example, both Donna (former Executive Director of NMHO Local) and Lucinda (current Executive Director of NMHO Local) described attending a gathering of all NMHO Executive Directors across the country as well as Advocacy Days hosted by NMHO Indiana and NMHO National that took place at the Indiana Statehouse and on Capitol Hill in D.C. At one of those events, Lucinda met April, and April connected Lucinda with Indiana representatives in the United States Congress (Personal communication, November 9, 2019). Additionally, both Donna and Rita (Program Director at NMHO Local) emphasized their ability to call or email just about anyone at the national level and receive some sort of response. According to Donna: "Our lobbyists and everyone … we have total access to them. I can pick up the phone and call any of them …. Anything you want goes through to the top level" (Personal communication, October 26, 2018).

Nonetheless, my analysis shows that, despite NMHO's grassroots structure and open communication channels, power within the organization, especially in terms of advocacy initiatives, tends to flow from national to state to local. NMHO National dictates the advocacy goals and priorities and performs a majority of the advocacy work for the entire organization. Based on the data that I gathered, this was apparent in three different ways: 1. NMHO National produces and circulates the most advocacy materials across all three levels. 2. NMHO National produces and circulates templates for advocacy materials that are passed down to the state and local levels. 3. NMHO National determines the advocacy priorities of the entire organization, which are detailed in a central document available on the NMHO National website. However, the evidence in my study also suggests that NMHO Indiana and NMHO Local determine their own priorities within the confines of NMHO National's guidelines.

First, NMHO National produced significantly more advocacy materials than the other levels during the same time period. As demonstrated in Table 1, from July 2011 to June 2019, NMHO National produced and circulated 360 advocacy materials, including amicus briefs, blog posts, C-SPAN Q&As, emails, fact sheets, forums, governance documents, letters, magazine

issues, memos, news articles, one-pagers, presentations, press releases, reports, testimony, and web pages. On the other hand, in that same time period, NMHO Indiana and NMHO Local produced and circulated 29 and 20 advocacy materials, respectively. NMHO Indiana's advocacy materials included emails, newsletters, one-pagers, reports, and web pages while NMHO Local's advocacy materials included newsletters, one white paper, and one web page. Although each level cites advocacy as a part of their mission, NMHO National produces a majority of the materials that get circulated both within and outside of the organization. As an example, in 2018, NMHO as an organization joined a lawsuit against the Trump Administration to overturn a ruling that allowed short-term, limited duration health insurance plans. After the filing, NMHO National circulated information externally to their membership base through a news article and also shared a copy of the civil complaint sent to the United States District Court for the District of Columbia. They also sent out a memo to NMHO leaders at all levels to inform them of the lawsuit in addition to a separate document with talking points in case state or local level affiliates wanted to comment on the suit. NMHO Local then shared information about the lawsuit in their monthly newsletter using the guidance from NMHO National.

Table 1: The number of advocacy materials produced by each level of the NMHO, broken down by genre, between January 2011 and June 2019

Genre	**# of documents published by NMHO National**	**# of documents published by NMHO Indiana**	**# of documents published by NMHO Local**
Amicus Brief	2	0	0
Blog	108	0	0
Governance Docs	3	0	0
C-SPAN Q&A	5	0	0
Email	4	1	0
Fact Sheet	4	0	0
Forum or Panel	1	0	0
Letter	8	0	0
Magazine/Newsletter	16	14	18

Table 1 continued

Memo	4	0	0
News Article	122	0	0
One-Pager	17	2	0
Presentation	2	0	0
Press Release	16	0	0
Report	19	2	0
Testimony (Written or Verbal)	8	0	0
Web Page	21	10	1
White Paper	0	0	1
Total:	360	29	20

Second, NMHO National creates advocacy materials that are specifically meant to be used as templates and passed down to the state and local levels. For instance, in 2017, NMHO National published a guide for state level organizations that want to advocate for the expansion of first episode psychosis programs. In the guide, there is sample language for a piece of legislation, talking points when communicating with state legislators, a sample advocacy alert email that can be sent to NMHO members, a sample email that can be sent to state legislators, and sample social media posts. These sample documents essentially cover an entire advocacy campaign for a particular mental health issue. April also describes creating sample documents for a variety of topics: "when we do an [advocacy] alert, we don't just write an alert … we also write a letter … that that person can send, that they can add to—that they can edit and then it to their member [of Congress]" (Personal communication, November 9, 2018). Gabrielle at NMHO Indiana will also forward messages from the national level to local affiliates, and she creates images as well as sample posts that members and local affiliates can use on social media to advocate for legislative issues at the state level (Personal communication, October 29, 2019). Lucinda confirms that these materials do get circulated down to the local level, as she says that NMHO Local uses national and state materials to stay informed and help them craft their own statements (October 1, 2018). Thus, advocacy materials that get circulated within the

organization primarily flow from national to state to local, and NMHO National circulates the most advocacy materials externally to its membership base and legislative officials.

Third, NMHO National determines the entire organization's stances on mental health issues and their legislative agenda/priorities. One document in particular written by NMHO National seems to serve as the "anchor" of NHMO's agenda: a 74-page public policy platform. This document is directed at NMHO National board members, NMHO National staff , and state/local affiliates to provide guidance on mental health policy issues. It is intended as a comprehensive source that any member, no matter the level, can consult to ensure their advocacy messaging follows the organization's guidelines. The public policy platform includes NMHO National's priorities in terms of populations that they serve (for example, individuals with serious mental illness, veterans, children, individuals who are homeless), as well as their stances on topics related to treatment; services and support for children, adolescents, young adults, and families; services and support for adults; funding for treatment and services; mental health research; quality monitoring, accountability, and accreditation of mental health professionals; legal issues; and criminal justice. The document also includes a section on the organization's identity and mission, the use of inclusive and non-stigmatizing language, and a statement condemning discrimination against people with mental health conditions. So, essentially, it's a "one-stop-shop" for NMHO's stances and priorities.

In addition to the public policy platform, NMHO National has a dedicated public policy section on its website so that their positions can be easily accessed without having to scan or search through a long document. Within that section is a page titled "National Policy Priorities" that identifies what the organization considers the most pressing policy actions that need to occur to improve mental health outcomes: 1. Funding mental health services/treatment and research, 2. Supporting early intervention programs, 3. Integrating mental and physical health care, and 4. Supporting caregivers, military service members, veterans, and other vulnerable populations. This page essentially condenses the public policy platform and identifies where the organization as a whole will focus their efforts. The public policy section of the website also includes pages that explain some of the topics/issues embedded within those priority actions, which include access to treatment, the death penalty, extreme risk protection orders (ERPOs), family education and support, the insanity defense, jailing people with mental illness, juvenile justice, Medicaid, Medicaid expansion, the Medicaid Institutions for Mental Diseases (IMD) exclusion, Medicare,

mental health in schools, mental health reform, mental health screening, parity for mental health coverage, psychiatric advance directs (PAD), supplemental security income (SSI) and social security disability insurance (SSDI), and tobacco and smoking.

We can see the influence of the public policy platform and the public policy section of the website in the topics that are addressed throughout the materials in the dataset. As a part of my data analysis, I coded each document according to the topics addressed within them. Across all NMHO documents published and circulated at the national, state, and local level, the most common topics included the following:

- Mental health reform (i.e., issues related to insurance and access to treatment, such as mental health parity, Medicare, Medicaid, etc.): Mentioned in 257 of 409 total NMHO documents.
- Funding of mental health research and programs: Mentioned in 166 of 409 total NMHO documents
- Mental health treatment (i.e., early intervention/diagnosis for better treatment outcomes and integrated care—especially in terms of community health clinics): Mentioned in 125 of 409 total NMHO documents
- Issues related to criminal justice: Mentioned in 122 of 409 total NMHO documents.

All of those topics appear in the public policy platform and, perhaps most importantly, they are all included as part of the "national policy priorities," which include increasing funding for research, expanding access to mental health treatments and services, and demanding mental illness not be made a crime.

At the state level, Ann, NMHO's Criminal Justice Director, says that they "always try to be consistent with what [the organization] at the national level is doing" (Personal communication, October 23, 2019). We can see the influence of the public policy platform and the national priorities by looking at NMHO Indiana's own public policy platform and the topics most commonly addressed within the state level advocacy materials. The priorities outlined in the NMHO Indiana public policy platform include issues related to criminal justice, the death penalty, restraint and seclusion, homelessness, access to treatment, children and adolescents, and funding. Additionally, across all NMHO Indiana documents, the most common topics coded include criminal justice, health care reform, Medicaid, and treatment.

All of these issues are addressed using the same language/terminology in the national public policy platform; however, NMHO Indiana's priorities are slightly different from NMHO National. Both NMHO National and NMHO Indiana cover the same top three topics across their advocacy materials: criminal justice, health care reform, and mental health treatment. Nevertheless, the number one topic for NMHO National is health care reform, while the number one topic for NMHO Indiana is criminal justice, particularly in terms of crisis intervention training, which most likely stems from a piece of legislation passed in 2015. Much of Ann's job as NMHO Indiana's Criminal Justice Director is providing assistance to crisis intervention teams across the state of Indiana as well as developing CIT training for law enforcement and corrections groups across the state. But Ann was also involved in P.L. 115 passed by the Indiana General Assembly in 2015. P.L. 115 requires the Indiana Law Enforcement Board and the Division of Mental Health and Addiction to establish a CIT Technical Assistance Center that will provide support to local coalitions who run CIT trainings across the state. It also requires all law enforcement trainees to undergo crisis intervention team training as a part of their education. This law passing was significant for NMHO Indiana and the entire mental health community in Indiana, so it received ample coverage to first bolster support for the initiative and then to celebrate its passage. NMHO Indiana's quarterly newsletter began covering the legislation in 2014 and continuing covering it through 2017 because the law did not include funding for the center. The law was then updated in 2017 with P.L. 102, which allowed the Indiana commission to create grants for the center. P.L. 115, as well as NMHO Indiana, also received recognition from NMHO National in the form of a blog post published on June 25, 2015 and in their 2015 report on the status of state mental health legislation. At that point, there was not yet federal funding or support for crisis intervention teams. Also, despite the implementation of the 21st Century Cures Act, which does include grants for crisis intervention teams, the responsibility of developing and training those teams is still that of the states. This may explain why there is less emphasis on this issue at the national level.

NMHO Local, while heavily influenced by NMHO National and NMHO Indiana, also has its own priorities when it comes to local legislation and policy. While NMHO Local does not produce much of its own advocacy materials (much of the advocacy messaging that they circulate within their newsletters comes from statements crafted by national, or is focused on state legislation), in 2017 they published a white paper on the mental health workforce shortage

and access to treatment within one of the counties that they serve. This white paper was authored by Donna in collaboration with two other local community leaders who coordinate a county mental healthcare forum. Eliminating workforce shortages are a part of NMHO National and NMHO Indiana's public policy platforms, and it is a topic that gets addressed in several materials circulated at the state and national level. However, it is significant that the authors chose to focus on the workforce shortage over other priorities laid out in the state and national platforms. It suggests that this problem may be more of a crisis in particular regions at the local level, and also that it may not be sufficiently addressed through national and state legislation.

While power and influence are concentrated at NMHO National, NMHO State and Local have some ability to dictate their own priorities and make an impact beyond their level

Although, in general, power and influence within NMHO advocacy initiatives flow from national to state to local, there are several examples where NMHO Local and state organizations have made an impact or received recognition from a higher level within the organization. NMHO Local's white paper on the workforce shortage is perhaps one of the best examples. According to Donna, "the white paper is the thing that had the most impact" (Personal communication, October 26, 2018). During our conversation, she detailed how the white paper got circulated at the local level and beyond:

> The white paper was something that I wrote for the mental healthcare forum … and I thought it would only serve a local purpose. And then I sent it to the state level, and I sent it to all the affiliate Executive Directors working in the state and then we had the [Executive Director's event] in Washington D.C., and I gave it to everybody there. So then national had it and then we had Hill Day. I just really milked that paper. We took it to Hill Day, and we gave it to Senator Donnelly's office and Senator Young's office … and when he came on invitation from the Chamber of Commerce, he met one of the staff members and he already knew about the document, which was pretty cool. (Personal communication, October 26, 2018)

Evidence of the document's impact within the organization can be seen at the state level through its presence in several issues of NMHO Indiana's newsletter: First, the Fall 2016 newsletter cites the results of a survey developed for the white paper as evidence for the workforce shortage across the entire state. Then, they mention the white paper itself in the Winter 2017 issue and link to where it is published on the NMHO Local website.

Later in her interview, Donna also goes on to describe the document's impact outside of the organization and how NMHO Local and their partner organizations have used it and referred back to it whenever they are working on issues related to mental health workforce shortages. After the document was circulated, she attended a meeting for the Mental and Behavioral Health Workforce Taskforce in Indianapolis. Based in part on the information presented in the white paper, the individuals running the taskforce decided that it was necessary to conduct another workforce study at the state level. In sum, this document, that was originally created to raise awareness for a local problem, ended up receiving attention all the way up to the national level and affecting change at the state level.

Like NMHO Indiana, NMHO National will also highlight the contributions of state organizations and local affiliates in their advocacy materials. NMHO Indiana, for instance, was recognized in a 2016 blog post for their role in getting P.L. 115—the crisis intervention law—passed in the Indiana General Assembly. Furthermore, in the Fall 2016 edition of their quarterly magazine, they published an article written by NMHO Indiana's former Communications and Policy Director and current Executive Director, Gabrielle, which profiled research on stigma performed by an Indiana University college professor. NMHO National has also profiled other state organizations—and also some local affiliates—in other blog posts or magazine articles, including NMHO Minnesota, NMHO New Mexico, and NMHO Dallas. These examples are exceptions to this study's first finding and demonstrate the complexity behind the relationships and communication flows that exist within an advocacy organization like NMHO.

Federal, state, and local legislative bodies often have different priorities/values and less open communication channels among them; however, power and influence are still concentrated at federal level

The communication channels among federal, state, and local legislative bodies are not as open as the communication channels among the different levels of the NMHO because they are all separate entities who work independently of each other. While the laws passed by federal legislators affect the entire country, state laws only apply to those who live within that particular state, and local laws only affect those who live in a particular city or county. Unlike the NMHO Local affiliates, state and local legislative bodies are not collaborating and working together

toward a common goal. Additionally, because of their varying constituent bases, state and local legislators may have values/priorities that differ from legislators at the federal level.

In terms of mental health legislation, we can see these differing priorities emerge through the different levels' focus on opioids. The United States as a nation currently faces an opioid crisis. According to the National Institute on Drug Abuse (2019), more than 130 people a day die from an opioid overdose, and the total number of overdoses increased by 30% from July 2016 to September 2017. However, the Midwest saw overdoses increase by 70% over the same time period. Of the ten pieces of federal mental health legislation surveyed in this dataset, two of them, the 21st Century Cures Act (2016) and the MHPAEA (2008), attempt to address this opioid crisis. Both the MHPAEA and 21st Century Cures Act strengthen insurance coverage for substance use treatment. The 21st Century Cures Act also provides grants to help with substance use prevention, treatment, and recovery; and strengthens leadership and oversight on issues related to substance use at the federal level. These are both significant, comprehensive pieces of legislation, so the inclusion of substance use within them speaks volumes of the severity of the problem at the national level. However, in Indiana, the sheer number of substance use/mental health laws passed between the years 2010 and 2019 show how much the worse the opioid crisis is in that region. In that time period, the Indiana General Assembly passed 88 public laws that address mental health, and 41 (nearly half) of them focused on either opioids in particular or substance use more generally. In fact, almost every public mental health law in 2017—the year in which opioid overdoses increased so sharply—focused on opioids and substance use (2017 ACTS, 2017). While addressing the opioid crisis is valued at the federal level, certain state legislatures, like Indiana, must make it one of their highest priorities because the problem is so much more severe than the national average.

Although federal, state, and local legislatures do not always have the same values or open communication flows among them, power and influence—much like the NMHO—flow from federal to state to local. For instance, the main piece of local legislation included in this dataset designates funding to community mental centers between the years 2015 and 2019. A section of the Indiana Code requires that counties fund community mental health centers a particular amount each year (Indiana Code Title 12, Human Services § 12-29-2-2). A portion of that funding comes from the county's budget, another portion from the state's budget—which sets aside a certain amount of money for community mental health centers every other year—and,

finally, federal funding from a Community Mental Health Services Block Grant, which is passed from the state to the counties where centers are located. In this case, the "power" (funding) is hierarchal in that it begins at the top with the federal legislature and then flows to the state legislature who then divvies the funds that flow to the local.

In another example, comprehensive pieces of federal legislation that significantly alter the mental health care system, like the Affordable Care Act, require states to update their existing laws in order to comply with new regulations and standards. In 2011, the Indiana General Assembly passed P.L. 160, titled "Federal health care matters" that begins with "Implementation of the Patient Protection and Affordable Care Act." The law essentially echoes the main regulations within the ACA, namely tighter regulations of accident and sickness insurance policies, what a health insurance plan is required to cover, and who is eligible to receive Medicaid.

However, several sections of the law challenge the rules set forth in the ACA. For example, one of the most controversial aspects of the ACA was the requirement to buy health insurance. Failure to purchase insurance either through an employer or through the healthcare marketplace would result in a tax penalty. In P.L. 160, section 3 states, "Notwithstanding any other law, a resident of Indiana may not be required to purchase coverage under a health plan." The ACA ultimately overrides any state law, which most likely means that the state of Indiana will not penalize any individual for failing to purchase health coverage, in addition to the federal tax penalty. However, it does appear to be a reaction to the ACA's regulation, as a way to show residents that the Indiana General Assembly does not approve of this federal regulation and will not be enforcing any additional penalty. In another section, the law requires the Office of the Secretary of Family and Social Services and the Department of Health to investigate submitting a waiver that allows them to use alternative programs/strategies that would provide Indiana residents with the same level of coverage and protections as the ACA. This is where the Healthy Indiana Plan emerged. The Healthy Indiana Plan is the state's alternative to Medicaid expansion. While some states raised the income threshold for Medicaid recipients, others applied for waivers that allowed them to create their own alternatives available to individuals who don't qualify for traditional Medicaid but whose income is still within the federal threshold. The waiver is federally sanctioned, so it's not as much of a statement against the ACA like the

previous example, but it is a case where the state of Indiana is asserting power and not allowing the federal government to dictate how it provides coverage for this particular group of people.

NMHO National has most direct effect on federal legislation, but some influence over state and local

Since they are located in Washington D.C. and are most focused on national mental health priorities, NMHO National communicates most directly with federal legislators and has the most influence over federal legislation. Within the dataset for this project, there are 34 documents/media produced by NMHO National that are addressed directly to federal legislators. These documents include letters, emails, reports, one-pagers/white papers, fact sheets, amicus briefs, and written or verbal testimony. These documents are typically composed to represent the views of the entire organization, but there are certain staff members who are in charge of either composing those documents or speaking directly to legislators in more formal, face-to-face settings. For example, both April and Ben, the Director of Legislative Policy Advocacy at NMHO National, describe the different ways that they communicate with Congress members. Ben is a registered lobbyist, so he attends formal meetings with Congress members or their staff to discuss issues related to mental health and key bills that may be up for debate (Personal communication, November 13, 2018). April does not meet face-to-face with Congressional members, but she does write letters, emails, and other correspondence that reaches federal legislators (Personal communication, November 9, 2018).

According to both April and Ben, their communication with state and local legislators is more limited. Ben said, "most of our state and local organizations do that, but … the goal is that the [national office] can support those efforts in dealing with legislators or state policy" (Personal communication, November 13, 2018). So, although NMHO National may not have direct communication with state or local legislators, they may indirectly influence laws at the state or local level because of the support that they provide for their affiliates. As stated previously in the chapter, NMHO National produces templates that state and local leaders can edit and send to their legislators. They also provide tips and talking points that they can use while advocating within their state. One such document, published and circulated in 2015, provides tips for increasing the mental health budget within the state. Those tips include learning the state budget cycle and developing relationships with Medicaid and behavioral health agency officials.

Additionally, the national level does keep track of what's going on in the state legislatures and attempts to hold them accountable or use them as examples in some of their advocacy materials. For example, in 2015 NMHO National released a report that evaluated states on several key issues, including funding for mental health, Medicaid and Medicaid expansion, health insurance parity, mental health workforce, early intervention, and criminal justice. The report essentially points out what states are doing well and how they can improve. This document is written for NMHO state leadership so that they can determine how well their state is doing and also get ideas from other states that they can then present to their representatives. Furthermore, this document is freely available on their website, and was also promoted and linked to in several of their blog posts, so it can be accessed by any NMHO member, or even legislators or simply anyone who is interested in mental health. Other ways that NMHO National will recognize state efforts—or failures—include blog posts, their quarterly magazine, annual reports, and C-SPAN Q&As. In most cases, they will use these documents/media to recognize successes and applaud state leaders' and legislators' efforts. However, they have used their appearances on C-SPAN to call out problems within state legislatures. For example, in 2014, NMHO National's executive director called out Alaska, Louisiana, Michigan, North Carolina, Rhode Island, Nebraska, and Wyoming because they all decreased their funding for mental health services.

NMHO Indiana has most direct effect on Indiana state legislation, but some influence over national and local

While NMHO Indiana does receive significant support from NMHO National, they are the primary communicators with Indiana legislators and therefore have the most direct power and influence over state legislation. Like NMHO National, some NMHO Indiana leaders communicate with legislators primarily through documents like letters, reports, and one-pagers, and others will communicate more directly with state legislators. For example, Ann, NMHO Indiana's Criminal Justice Director, says she communicates with one particular state senator "who has been a CIT champion" several times a year because he helped pass the bill which established the CIT Technical Assistance Center (Personal communication, October 23, 2018).

However, NMHO Indiana may also have influence over some local legislation because of the support they provide local affiliates. Additionally, they have the potential to influence federal

legislation if NMHO National champions a state initiative, or if they participate in federal initiatives of their own volition. As stated previously, NMHO National recognized NMHO Indiana for their efforts in getting CIT legislation passed by the General Assembly. This same piece of legislation, along with another that appoints representatives for inmates to apply for Medicaid and secure treatment at the time they are discharged, were also recognized in NMHO National's evaluative report on mental health in the states, which means that they were used as examples for national and other state leaders. NMHO Indiana staff members also have the ability to communicate more directly with federal legislators at NMHO National's Hill Day, which is held annually on Capitol Hill in Washington D.C. Any NMHO member, no matter their level of affiliation, can attend and have the opportunity to share their story or discuss the issues with federal officials.

NMHO Local has most direct influence on local and state legislation, but also directly communicates with legislators at all three levels

Unlike NMHO National and NMHO Indiana, who both seem to have the most direct influence on the legislation at their corresponding levels, NMHO Local seems to have some influence over both local and state legislation. Although NMHO Local does not produce as many of their own advocacy materials as NMHO Indiana and NMHO National, there are several key ways that they are able to communicate with local and state legislators and therefore influence legislation. One way is through an annual legislative forum. According to both Lucinda and Donna, NMHO Local—in collaboration with several other mental health/substance use organizations in the area—invites state representatives to participate in a forum on mental health/substance use issues within the region. Each of the organizations will prepare questions to ask the representatives, but all members of the community are invited to attend and encouraged to ask questions as well. The purpose of the event is not only to learn about representatives' mental health/substance use platforms but also to put pressure on the representatives to make mental health/substance use a priority as well as to give the community a voice. Furthermore, Donna wrote the workforce shortage white paper for one of the legislative forums, and, as stated previously in the chapter, it went much farther beyond the local organization, making it all the way up to the national level.

In fact, because of the white paper and her connection with local legislators, Donna was able to secure a meeting with a state senator who was the head of the health subcommittee in the Indiana General Assembly. However, the meeting revealed that there was clearly a misunderstanding of the role that NMHO plays. According to Donna:

> He actually drove specially to [our town] to meet with us, and what the two of them were expecting us to do—we were completely floored because we were obviously not prepared—is they were expecting us to have legislation written for them that they can then propose. [The local organization] is not there to write legislation. That is not what an affiliate does …. And that time, it was my first year, I was not in the position to write legislation …. I said what I can do is — those who do write legislation—I can get in contact with them, and we supported the … umbrella organization that covers community mental health organizations. (Personal communication, October 26, 2018)

This example shows that NMHO Local is limited in the direct legislative input that they can provide; however, without Donna's white paper and her connections to other organizations, state legislators would not necessarily have this issue on their radar, and it may have gone unaddressed. "So really, we have not created the documents, but we kind of got things going," Donna said. "I mean, I'm amazed with how far you can go with being such a small organization like that" (Personal communication, October 26, 2018).

In addition to the success of the white paper, NMHO Local, in particular Lucinda and Donna, has been able to visit the state and national capitols. NMHO Indiana hosts an annual Advocacy Day where NMHO members across the state can meet legislators and talk with them about the mental health issues most important to them. NMHO National has Hill Day, which has the same set up as Advocacy Day but at the national level: NMHO members across the country gather at Capitol Hill to meet with federal legislators and talk with them about mental health and substance use. It was at Hill Day that Donna was able to give her white paper to both Senator Donnelly's and Senator Young's offices. Donna was also able to meet with Senator Young's health representatives. At that meeting, she realized how little these officials, even those who are supposed to be in charge of these issues, know about mental health:

> I remember Senator Young's health representative saying to me, 'Well, Senator Young is really not that interested in mental health right now; he really is more interested in the opioid crisis.' He said that two days before they were supposed to vote on mental health care spending. So, I looked at him, and I told him, 'That's very interesting, but if you cut spending and people can't afford their meds anymore, what do you think they will turn to help them get relief?' And he just

> looked at me and said, 'Oh, I don't think we ever thought of it that way.' (Personal communication, October 26, 2018)

It's not clear whether Donna's meeting with this representative caused Senator Young to care more about mental health or to vote in a certain way concerning the budget. But, in that moment, Donna was able to help the representative see that issue from a different perspective, which, in itself is an impact.

Conclusion

Major Finding 1 reveals that while each stakeholder/component within this legislative-advocacy assemblage has the ability to enact change, a component's level of power greatly influences the effects of its communication efforts. Additionally, open channels of communication along with shared priorities/values make it more likely for a component with less power to impact other components within the assemblage. This portion of the study examined the power dynamics and communication channels across the entire legislative-advocacy assemblage but also broke it down into two "nested assemblages": the NMHO as an organization and the legislative bodies (DeLanda, 2016). As shown in Table 1, NMHO National produces the most advocacy materials and dictates the organization's advocacy strategy through its public policy platform, so overall its communication efforts have the greatest effect across the assemblage. However, because NMHO is a united grassroots organization with open communication channels between each level, NMHO Indiana and NMHO Local can (and have) produced change within the organization. With the three levels of legislation, on the other hand, there is less of an opportunity for state or local legislation to impact the federal because they are three separate entities with different priorities.

In terms of the relationships among the nested assemblages, each level of the NMHO typically has the most direct effect on its corresponding level of legislation (NMHO National to federal legislation, NMHO Indiana to Indiana state legislation, and NMHO Local to local legislation). Nonetheless, because federal and state legislators serve a greater number of people than local legislators, NMHO Indiana and NMHO Local have the ability to influence legislation beyond their level because they are constituents of United States and Indiana State Senators and Representatives. The subsequent sections focus more on the relationships between advocacy materials and legislation and demonstrate how the two the impact each other. Major Finding 2

specifically focuses on how federal, state, and local legislation influences the advocacy materials produced by the NMHO.

4.2.2 Major Finding 2: NMHO's advocacy materials are often reactions to legislation and other policy initiatives

As Major Finding 1 demonstrates, the different levels of legislation and the NMHO are in constant interaction, and the NMHO has the opportunity to influence federal, state, and local legislation in a variety of ways. Therefore, the next question of my study instead focuses on how legislation affects NMHO advocacy materials: "How does federal, state, and local legislation impact the advocacy materials produced by mental health advocacy organizations?" My analysis of NMHO's advocacy initiatives found that, in most cases, the advocacy materials that they create are reactions to legislation and other policy decisions made by legislative bodies at the national, state, and local levels. We see this occurring in two ways: 1. The topics addressed within NMHO's advocacy materials reflect the content within the legislation. 2. A significant portion of the advocacy materials involve either supporting or condemning legislative acts as they are introduced or passed.

As mentioned in the previous section, the NMHO has a public policy agenda that they use to guide their advocacy initiatives and the content that they circulate within their advocacy materials. Some items in the agenda are rooted in current policy/legislation, but others are more long-term goals—almost like a sort of "wish list" of policies based on research and evidence-based best practices. This finding demonstrates that while the NMHO may always have long-term goals in mind, a majority of their advocacy work is dictated by past and current legislative priorities.

The topics addressed in NMHO's advocacy materials reflect the topics discussed in the legislation

As I was analyzing the documents/media in my dataset, I created codes based on the topics addressed within them and also noted whenever one of the advocacy materials referenced a piece of legislation. I noticed that each year, as new legislation was proposed or new policy initiatives unfolded, NMHO's advocacy materials would more heavily focus on those particular pieces of legislation and the topics addressed within them.

Because both the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) were comprehensive pieces of legislation that essentially altered the landscape of health insurance in the United States (and continue to dominate as the laws of the land when it comes to healthcare), they and the major topics within them—namely healthcare reform, Medicaid, and parity—are prominent throughout NMHO's documents: At NMHO National, the ACA is mentioned in 69 documents, reform in general is mentioned in 257, parity in 110, and Medicaid in 139. The MHPAEA and the ACA were passed in 2008 and 2010, respectively. However, the MHPAEA's clarified rules and regulations were not finalized and published until 2013, and many of the ACA's major provisions did not take full effect until 2014. It was in 2013/2014 that NMHO began to more heavily address healthcare reform by publishing significantly more media on the subject. In 2012, only 7 documents published by NMHO addressed healthcare reform. By 2013, that number tripled to 21 documents, and then 24 in 2014. Then, the topic of healthcare reform became even more prevalent in 2015 and 2016, which was most likely due to the 21st Century Cures Act. While the 21st Century Cures Act was only mentioned by name in 23 documents at the national level and two at the state level, it's clear that the topics addressed within it were addressed heavily within those two years: Reform was mentioned in 44 NMHO National documents in 2015 and 47 in 2016—more than any other year included in the dataset. Treatment was also mentioned in more documents than any other year: 19 in 2015 and 25 in 2016. The same applies with criminal justice: 19 documents in 2015 and 18 in 2016. All three of these topics are main components of the 21st Century Cures Act.

In terms of NMHO Indiana, the most prominent influence seems to be from criminal justice and P.L. 115, the crisis intervention law passed in 2015. In 2015, 2016, and 2017, NMHO Indiana produced three, five, and four documents, respectively, that addressed criminal justice issues. Criminal justice is also one of the most common topics addressed in documents with no publication date (such as web pages), which suggests that criminal justice is an ongoing issue/priority within the Indiana legislative system. Federal legislation also seems to influence NMHO Indiana: the Affordable Care Act is mentioned in four documents, reform is also mentioned in four, parity in three, and Medicaid in ten.

However, it is not just formal legislation that seems to influence NMHO advocacy materials: significant events that lead to conversations about changes in policy can also cause NMHO to react through their advocacy. In both 2013 and 2016, NMHO National discussed the

relationship between gun violence and mental illness in eight documents published and circulated each of those years. Every other year, gun violence was rarely mentioned, except in 2012 when it appeared in four documents. In 2012, two major mass shootings took place: the Aurora, Colorado movie theater shooting and the Newtown, Connecticut Sandy Hook Elementary School massacre. Both shootings led to conversations surrounding not only gun control but also mental health and the relationship between mental illness and violence. Gun control is controversial in the United States, so lawmakers will often instead propose legislation aimed at strengthening mental health treatment. Because of this, NMHO had to do some damage control: one pillar of their advocacy is reducing stigma against mental illness, and equating violence with mental illness serves to further stigmatize individuals who live with a mental health condition. Therefore, in those 12 documents published in 2012 and 2013, NMHO commended officials for their attention to mental health reform but denounced the connection between mental illness and violence.

In 2016, NMHO's advocacy materials that referenced gun violence were not centered around specific shootings. Instead, that year, President Obama announced several initiatives meant to address gun violence, one which included a $500 million increase in mental health funding within the federal budget. Like in 2012 and 2013 when similar conversations were occurring, NMHO National acknowledged that this budget increase and better access to services/treatment are desperately needed and therefore thanked the President for this initiative. However, they also emphasized that this link between mental illness and violence is harmful and troubling for individuals living with mental illness, as it serves to further stigmatize and stereotype them. Additionally, 2016 was an election year, so some of these documents were calling out candidates, or members of the media publicizing the election, for further instilling this link between mental illness and violence.

A significant portion of NMHO's advocacy is supporting or condemning legislative acts

Another way that the NMHO reacts to proposed or passed legislation is by either supporting or condemning it. One portion of my analysis involved coding each document for the "actions" it produced. Two such codes that emerged across all the NMHO advocacy were "approving a piece of legislation" and "condemning a piece of legislation." The code "approving a piece of legislation" was assigned whenever the NMHO expressed support for a bill or

celebrated when a law was passed. On the other hand, "condemning a piece of legislation" was assigned whenever the NMHO did not support a bill, or a law was passed that weakened mental health initiatives in some way. "Approving a piece of legislation" was the third most prevalent "action" code while "condemning a piece of legislation" was ninth.

The two bills that were perhaps pushed the hardest by the NMHO were the Helping Families in Mental Health Crisis Act in the House of Representatives and the Mental Health Reform Act in the Senate. These bills, which were first introduced in 2015 and 2016, respectively, were the first major bipartisan attempts at mental health reform since the Mental Health Parity Act. The NMHO knew there was a lot at stake with these two bills, so in 2015 and 2016, they advocated heavily through a variety of genres and audiences (letters to Congress, appearances on C-SPAN, blog posts and news article that explained the legislation to their members). As stated previously, the topic of mental health reform rose sharply within the dataset during the years 2015 and 2016, which were the two years that Congress debated these bills. The findings show that while mental health reform is a consistent priority across the years represented in the dataset, it is even more prevalent those two years because of the number of times the NMHO declared their support for the legislation. Also, when the bills were incorporated into the 21st Century Cures Act, which ultimately passed both the House of Representatives and the Senate and was officially signed into law on December 13, 2016, NMHO celebrated by announcing it to their members through blog posts and news articles as well as thanking Congressional officials and President Obama.

Although the NMHO did not condemn nearly as much legislation as they approved, one bill in particular received significant scorn within the dataset: the American Health Care Act of 2017. This bill would have repealed a portion of the Affordable Care Act, which would have included cuts to Medicaid and the option for states to revise the essential health benefits. Throughout the dataset, the NMHO consistently speaks positively of the ACA, particularly because of its Medicaid expansion and because it listed mental health as an essential health benefit that must be covered by insurers subject to the law. After the ACA passed and was fully implemented, many of NMHO's members became eligible for Medicaid when they previously were denied, and/or their insurance finally covered mental health treatments that they in the past could not afford. Therefore, the passage of the American Health Care Act and the subsequent repeal of the ACA would be detrimental for individuals living with mental health conditions. So,

in 2017, the "condemning a piece of legislation" code was especially prominent because 11 documents were focused on the American Health Care Act. It was also prominent in 2018 because of another challenge to the ACA: the Trump Administration's rule which would allow for the expansion of short-term, limited duration insurance plans. These plans can discriminate based on pre-existing conditions, and they are not bound to the essential health benefits listed in the ACA and, therefore, are not required to cover mental health treatment. The NMHO actually entered into a lawsuit with several other organizations to challenge the rule. Thus, the ways in which they condemned the rule were not only through channels like their blog or website, but also through memos, press releases, and emails that explained the lawsuit and their reason for getting involved.

Conclusion

Major Finding 2 reveals that the major topics addressed in NMHO's advocacy materials follow similar patterns to the topics that get addressed in the major pieces of legislation that are proposed and passed during the same time period. The ACA, the MHPAEA, and the 21st Century Cures Act seemed to have the most effect on NMHO's advocacy materials as those three pieces of legislation were mentioned most often by name. Furthermore, following their introductions to Congress and their subsequent passing, the NMHO heavily focused on healthcare reform, mental health parity, Medicaid, treatment, and criminal justice—all which are the primary issues addressed in the ACA, MHPAEA, and the 21st Century Cures Act. Additionally, several instances within the dataset demonstrate how the NMHO's materials are also reactions to significant events, such as mass shootings, that then lead to conversations about policy change.

Additionally, much of their advocacy focuses on either supporting or condemning specific pieces of legislation. Supporting legislation was especially significant as it was the third most prevalent action code that I identified during my analysis of the documents. The Helping Families in Mental Health Crisis Act in the House of Representatives and the Mental Health Reform Act in the Senate—both which eventually passed as a part of the 21st Century Cures Act—were the most heavily pushed by the NMHO because they were broad reforms to the mental health system. Although the NMHO does not spend as much time condemning legislation, in 2017 they used significant resources to push back against the AHCA and the Trump Administration's ruling on short-term, limited duration insurance plans—both of which

served to weaken the ACA. These findings reveal that while the NMHO does have long-term policy-related goals, much of the advocacy work within the NMHO involves reacting to legislative actions and current events.

4.2.3 Major Finding 3: The NMHO's advocacy materials impact legislation through direct communication to lawmakers as well as indirect communication from members

Since Major Finding 2 focused on how legislation impacts advocacy materials, this section will do the opposite and focus on how advocacy materials impact legislation. Therefore, the third question my study seeks to answer is "How do advocacy materials produced by mental health advocacy organizations attempt to impact federal, state, and local legislation?" My study found two ways that the NMHO is able to influence legislative outcomes: 1. By communicating directly with lawmakers and imploring them to support particular initiatives, and 2. By educating their membership about the issues and encouraging them to act on particular initiatives. In both instances, the NMHO used similar strategies to get their audience to act, such as pointing out problems in the current system and educating or informing about a mental health issue by citing statistical evidence or personal experiences. These findings are significant because they demonstrate several ways in which actors beyond legislative officials contribute to legislation.

Some NMHO advocacy materials/media are targeted directly to lawmakers

All three levels produced materials that, while widely available to the general public through their websites and social media, were directed specifically toward lawmakers:

- At the national level, there were 34 documents: eight pieces of written or verbal testimony, seven reports, eight letters, two amicus briefs, and nine one-pagers.
- At the state level, there were two documents: one report and one one-pager.
- And, finally, at the local level, there was one document: a white paper.

These documents addressed a wide variety of topics, including criminal justice, crisis intervention team training, violence, funding, supports and services for adults with mental health conditions, healthcare reform, veteran health care, workforce shortages, and access to treatment. Healthcare reform was by far the most prevalent, as it was the main topic in 20 out of 37 documents produced by all three levels. Criminal justice and treatment were the second and third most prevalent with 10 and nine documents, respectively.

These documents also attempted to accomplish particular goals and in turn produced particular "actions," which turned into codes I assigned as I performed my analysis. The two most prevalent actions produced by documents geared toward lawmakers were "calling for action," which was coded in 33 documents, and "pointing out a problem," which was coded in 32 documents. "Calling for action" was assigned whenever the NMHO attempted to compel legislators to take some sort of action. Most commonly, they would be putting pressure on them to do the following

- Vote or not vote for a particular bill (like the Mental Health Reform Act and the Helping Families in Mental Health Crisis Act, or the American Health Care Act),
- Revise the language in a piece of existing legislation (like the HIPAA privacy rule so that it provides more flexibility for family members of individuals with a mental illness),
- Provide more funding for mental health (i.e., through increases in the budget),
- Promote collaboration and integration (in terms of collaboration among government agencies and also integrating mental health with primary care and other medical specialties), or
- Shift their focus to a subject that had previously been neglected (like veteran's mental health care).

"Pointing out a problem" was assigned whenever the NMHO attempted to focus attention on an issue within the mental health system. In most cases, "pointing out a problem" went hand-in-hand with "calling for action" because the NMHO would be calling on lawmakers to fix a problem through legislative actions. For example, several documents geared toward lawmakers point out how health insurers are violating parity laws despite the final rules and regulations' publication in 2013. These same documents call on lawmakers to better enforce parity through legislation. At the state level, NMHO Indiana's report on psychiatric crisis intervention services first pointed out the limited resources for individuals experiencing a psychiatric crisis in Indiana. Then, they provide recommendations for state lawmakers as a "call to action" to fix the gaps in these types of services. NMHO Local uses the same strategy for their white paper on the workforce shortage: they point out the problem and then provide suggestions on how to fix it.

Another prevalent action that went hand-in-hand with calling for action was "educating or informing." In order to get legislators to support a bill or a cause, the NMHO would have to educate or inform them about the issues. As Donna stated in her interview, many legislators

simply don't understand the complexities of mental health or the issues surrounding it, so they need the knowledge and viewpoints of the NMHO and their members in order to make more informed decisions about mental health policy. The NMHO used two strategies to educate lawmakers: providing facts/evidence and citing individual's personal experiences with mental illness. Facts/evidence often come in the form of statistics that support claims or demonstrate a problem, and that evidence is often more in-depth/extensive in reports and one-pagers that lawmakers could read and reference in the future. For example, the report on mental health parity and the military provides extensive statistics on the number of veterans/active duty service members who have experienced mental health symptoms, the number who have attempted or completed suicide, their family members who are affected by mental health concerns, among other issues. NMHO Local uses a similar strategy in their workforce shortage white paper by providing graphs/charts that demonstrate the number of psychiatrists and other types of mental health providers per the number of people living in their county.

Personal stories of individuals' experiences with mental illness were used in conjunction with facts/evidence in the longer reports and were also commonly used in verbal or written testimony provided to congressional officials. For example, in the same parity report mentioned in the previous paragraph, the NMHO include quotes from service members and their families about their experiences with mental health and their attempts at getting treatment. In another example, an NMHO member testifies in front of Congress by first telling the story of how his mental illness developed and then about the quality of care he has received and his ability to access that care. NMHO using this combination of personal anecdotes and facts/evidence in their advocacy materials allows lawmakers to see the breadth of the issues, like how many people are affected by the mental health legislation that they pass, as well as the depth, like how an individual struggling to find treatment for their mental health condition experiences everyday life.

NMHO advocacy materials directed at members or the general public influence legislation indirectly

A majority of NMHO's advocacy materials are directed at their members and/or anyone in the general public who happens across them on the Internet:

- At NMHO National, 25 documents were aimed specifically at members, and 285 documents were produced for the general public.
- At NMHO Indiana, 16 documents were aimed specifically at members, and 11 documents were produced for the general public.
- At NMHO Local, 18 documents were aimed toward members and one toward the general public.

The documents geared toward NMHO members included issues of NMHO National's magazine, NMHO Indiana's newsletter, NMHO Local's newsletter, governance documents, presentations, one-pagers, emails, reports, and forums/panels. The documents geared toward the general public include blogs, news articles, press releases, C-SPAN Q&As, web pages, reports, fact sheets, governance documents, and one-pagers. These advocacy materials covered the same variety of topics as those directed toward lawmakers, and they also addressed the same top three topics: 1. Healthcare reform in 206 documents, 2. Mental health treatment in 97 documents, and 3. Criminal justice in 86 documents.

The "actions" that these types of documents produced were also similar to those geared toward lawmakers; however, they had different goals and outcomes. Just like the lawmaker materials, "calling for action" was the most prevalent action code across all the NMHO advocacy materials geared toward members and the general public. However, the actions that they were calling for are much different than the actions they wanted from lawmakers. For example, in a number of their blog posts that approved or condemned a piece of legislation, NMHO National would encourage anyone reading to contact their representatives in order to put pressure on them to either vote or not vote for a bill. Other prominent actions they called for include getting individuals to participate in an event, sign a petition, take a survey, or share their personal story related to mental health. The latter three would then often be used as evidence in reports or testimony provided to lawmakers.

NMHO also spent significant space in these advocacy materials "pointing out a problem," "approving a piece of legislation," "condemning a piece of legislation," and "educating or informing"—all of which would hopefully prompt individuals to act in some way. Many of these codes went hand-in-hand. For example, after the 21st Century Cures Act passed both the House and Senate and was then signed into law by President Obama, the NMHO in several blog posts not only signaled their approval of the legislation but also educated individuals

on what provisions were included in the law and what it would mean for them and pointed out the problems that it would fix. The NMHO did the same for the American Health Care Act, except they condemned it, educated individuals on what provisions were included and how it would affect them, and pointed out the problems it would cause or further exacerbate. In fact, much of the advocacy geared toward members and the general public was essentially translating legislative documents since they are often long (the Affordable Care Act is over 1,000 pages, for example) and written using complex, verbose language and sentence structures.

The NMHO also uses a combination of facts/evidence and personal stories in order to both demonstrate the severity of certain issues to their members and the general public and show the humanity behind those facts/statistics. The main difference here is that because the majority of advocacy materials geared toward the general public and members are shorter documents, like blogs, news articles, press releases, etc., the facts/evidence and personal stories included are often not as in-depth as what is provided in the longer reports or testimony provided to lawmakers. However, the NMHO does share much of their communication with congressional officials with members and the general public and thus enable them to read these documents if they want more information.

Conclusion

Major Finding 3 demonstrates how NMHO advocacy materials impact mental health legislation by both appealing directly to lawmakers and compelling supporters to put pressure on their representatives. Although the NMHO reaches these audiences using different media (i.e. more "formal" genres such as letters, testimony, and reports to legislative officials and more "informal" genres such as blogs, emails, and news articles to their membership base and beyond), they use much of the same strategies across the documents to persuade them to support mental health issues. Those strategies include pointing out problems in the current system and educating or informing using facts/evidence and personal stories from individuals living with a mental health condition and their family members. To many people, the process behind writing and enacting legislation may seem mysterious, and they may not be aware of how the opinions, knowledge, and research of stakeholders beyond lawmakers play into legislative decisions. This portion of the study provides a glimpse into how that process occurs within the realm of

advocacy and also demonstrates that power and influence is not completely concentrated within the legislative bodies that make up this legislative-advocacy assemblage.

4.2.4 Major Finding 4: Advocacy materials and legislative documents have material effects on the mental health system in the United States

Major Finding 3 and all previous sections have focused on how legislation and advocacy materials interact and impact each other. However, legislation and advocacy do not exist in a bubble, and these interactions often have profound effects on the material lives of individuals who live with a mental health condition. Thus, the final question this study seeks to answer is "How do advocacy materials and legislation impact the United States mental health system at the federal, state, and local levels?" As stated in previous sections, one category of coding that I used during my analysis included codes that I assigned whenever the language in a piece of media or text produced some sort of "action." My findings show that these actions generated by both the NMHO advocacy materials and the legislative documents led to material effects within the mental health system in the United States.

Language in advocacy materials can cause people to act in certain ways

As Major Finding 3 demonstrates, the main purpose of NMHO's advocacy materials is to get the people who read them—whether it's lawmakers, members, or the general public—to act in particular ways by educating them about the issues and pointing out problems in the system. Those materials directed at NMHO members or the general public will hopefully get them to call, email, or write to their representatives, provide testimony, sign a petition, or participate in an event meant to raise awareness about mental health conditions. Those actions, in combination with the NMHO advocacy addressed directly to legislators, will then hopefully put pressure on them to act and pass legislation that improves mental health outcomes in the United States.

According to both April and Ben at NMHO National, they are able to measure how many people email their congressional officials as a result of their advocacy campaigns, and they will often hear from staffers who inform them when they have received a number of calls about a particular issue. However, they both also acknowledged that, despite their ability to gather this data, it's difficult to know the exact impact that their initiatives have on elected officials and the legislation that they produce because "policy is a long game" with a lack of "measurable"

outcomes associated with it (April, personal communication, November 9, 2019). Furthermore, legislators will also receive and hear the viewpoints of other mental health advocacy organizations besides the NMHO, so it is difficult to determine which one actually swayed their opinions. However, according to April, the NMHO hired a firm to determine the amount of "space" that they owned within the communication surrounding mental health. Compared to other groups, the NMHO takes up 56% of the conversation space, meaning that they have significant name recognition and influence, and, as April says, "when [they] decide on something, it happens" (Personal communication, November 9, 2018). She then goes on to provide an example:

> So, the RAISE study, the Recovery After Initial Schizophrenia Episode study, when we knew that that data was coming out and that it was good, we partnered with NIH to do a congressional briefing on it to release the data. We also worked to make sure the media knew about it, and it was on the front page of *The New York Times* when it was released, and also in the *Washington Post* ….We were sitting around printing a fact sheet for the briefing ….and they had put 5% set aside in the mental health block grant to fund to start these programs because, you know, it works …. So, we had this briefing; we had a young woman who went through one of the programs at the briefing, and her mom comes and then we have the researchers talk. We wrote a fact sheet, and we were talking to each other, and at first somebody said, "Well, we want to continue the 5% set aside." And I think it was me, I don't know, but I was like, "Why don't we ask for doubling it?" And we're like, okay. So, we put double the mental health grant up from five to ten percent. And so then we did the briefing; we had the handout, and we were the only organization to ask for doubling of that block grant. And in the audience, I was looking at all these faces … when [the young woman] was talking about her experience and what a difference it was with going with this program and being able to live a full life and go to nursing school, be successful, the people in the audience had tears in their eyes. And then in the next budget, they had put 10% aside for early psychosis. (Personal communication, November 9, 2018)

As this example shows, the NMHO staff involved in this briefing used several strategies/materials to bolster support for early psychosis programs: First, they alerted the media through a press release in order to educate the general public and gain support for the cause. Then, they created a fact sheet to provide evidence on the benefits of early psychosis programs to congressional officials at the briefing. And, finally, they brought an individual who had completed one of the programs to provide testimony about the experience and how it helped her. Since they were the only organization that asked for a higher increase in funding, there is a high probability that this coordinated effort resulted in the action taken by congressional officials.

Language in legislative documents have material effects on the mental health system in the United States

When organizations like NMHO and their members/supporters engage with legislators, it puts pressure on them to then act and either revise existing mental health legislation or write and pass new legislation. The results of my coding and analysis show that different categories of language used within the legislative documents in my dataset generate various actions that then have material effects within the mental health system in the United States. Those categories, which emerged from my analysis using NVivo, are defined below:

- *Defining*: 1. When a definition of a word or phrase was provided; 2. When criteria or parameters were defined; 3. When eligibility requirements for a program, grant, or other service were provided by that particular legislative document.
- *Funding*: Whenever the legislation set aside funds for grants, programs, or organizations
- *Evaluating/assessing*: When lawmakers laid out a plan or stated an intention to evaluate the success of a program or evaluate the need for an intervention.
- *Establishing*: When a new program, organization, or group was created.
- *Mandating*: When legislation demanded that something be implemented or a procedure must be followed.
- *Restricting/limiting*: When the legislation prohibits something.
- *Permitting*: When the legislation allows something.
- *Coordinating/integrating/collaborating*: When the legislation established collaborative initiatives among agencies or discussed integrating different types of medical/mental health services.
- *Publishing/circulating*: When the legislation required that information be circulated and made available to the general public.

Defining is represented in 19 out of 24[4] legislative documents and is the most prevalent action code. The content represented in this code ranges broadly—from defining medical/health services to insurance terminology and even to groups of people—and the topics covered are dependent on the focus of that particular piece of legislation and who was most affected by it. For example, all of the legislative documents that address mental health parity provide detailed

[4] All Indiana state legislation passed in a single year is compiled into one document, so this number reflects the combined pieces of legislation between the years 2010 and 2019.

definitions of terms like, “medical/surgical benefits,” “mental health benefits,” “substance use disorder benefits,” “financial requirements,” and “treatment limits”—all of which are crucial for insurance companies to understand and follow the law. In fact, a significant portion of the final rules and regulations for the MHPAEA is used to define and clarify terms that may have been ambiguous in the initial legislation passed in 2008. The act of defining has material effects because it essentially brings something into existence. A definition sets parameters and determines what gets included and what gets excluded. And in terms of defining eligibility, it determines which people and programs get funding and which don’t. As an example, Medicaid’s income requirements determine who receives that particular form of health care and who doesn’t.

Funding is also represented in 19 out of 24 legislative documents and is the second most prevalent action code. Funding is tied to a variety of initiatives and programs within each piece of legislation, or to the total government budget at the national, state, or local level. For example, the ACA established and funded the federal program titled Investment in Tomorrow’s Pediatric Health Care Workforce, which provides scholarships for medical or professional students specializing in a pediatric mental health career who agreed to work in an underserved area after their graduation for a specified amount of time. In terms of legislation, the phrase “money talks” is quite literal: funding signals a government’s priorities and what is valued. It also determines whether or not an initiative will actually be accomplished. As Leslie from NMHO Indiana states, “it’s hard to help people or provide resources if at the state or federal level they aren’t helping with that, writing legislation to allow for funding and everything” (Personal communication, October 23, 2019).

Restricting/limiting and *permitting* are two sides of one coin. However, *restricting/limiting* was much more prevalent in the legislation—third out of all the action codes—and appeared in 15 out of 24 legislative documents, while *permitting* was seventh and only appeared in 12 out of 24 legislative documents. While there are quite a few provisions within the larger pieces of legislation that either restrict/limit or permit, there are several smaller documents where one of those two actions is their entire purpose. For example, the ruling in *Miller v. Alabama* prohibits mandatory life sentences without parole for juvenile offenders because of the mental health impacts, and the HIPAA Privacy rules permits medical professionals to share mental health information with an individual’s family members if they are

deemed a danger to themselves or others. Similar to defining, *restricting/limiting* and *permitting* essentially determine what is allowed to exist or occur.

Establishing and evaluating/assessing also seem to go hand-in hand. Establishing is the fourth most prevalent action and is represented in 17 out of 24 documents while evaluating/assessing is the sixth most prevalent action and is represented in 18 out of 24 documents. In a majority of the legislative documents where these codes are prevalent, whenever a program gets established, lawmakers also provide a procedure for evaluating or assessing the program, or the program is expected to assess the issue that it was created to address. For instance, in 2015, the Indiana General Assembly passed a law that established the Indiana Technical Assistance Center for Crisis Intervention Teams. In that law they not only described the purpose and goals of the center, but also how that center would assess the performance of crisis intervention teams across the state of Indiana. However, not all *evaluating/assessing* codes are connected to *establishing* codes. For example, in 2014, the Indiana General Assembly passed an initiative where the State Department of Health, in collaboration with Indiana Department of Veterans' Affairs and the Division of Mental Health Addiction, conduct a study on treatment for veterans with a traumatic brain injury or posttraumatic stress disorder. No *establishing* code was assigned with this *evaluating/assessing* code because all three organizations conducting the study existed prior to this legislation. Additionally, the study was meant to show the need for a particular type of program, but the program had not actually been established. In terms of material effects, when legislators establish a new program they are literally creating resources and bringing people together to work on these programs. Furthermore, their evaluations will determine if they program gets to continue, or even exist in the first place.

Mandating was the fifth most prevalent action code and was present in 15 out of 24 legislative documents. In particular, it was most represented in the federal parity acts, which demand that insurance companies change their practices and implement new procedures for covering mental health. It also had a significant presence in Indiana state acts that addressed insurance coverage, like P.L. 160 passed in 2011, which reaffirms many of the provisions set forth in the ACA. A mandate means that something must happen or there will be consequences. Without the mental health coverage mandate in the parity acts, many insurers still would not provide mental health coverage as a part of their plans. This is in contrast to instances in the legislation where lawmakers essentially provided their opinion on an issue (in federal legislation

this is called a "Sense of Congress") or "urged" committees or lawmakers to perform some sort of action but did not require it. For example, two pieces of Indiana state legislation passed in 2018, P.L. 68 and P.L. 202 "urge" committees to conduct studies on pharmacy deserts and convert underused or unused spaces into substance use treatment programs, but they do not require them to do it, or provide any additional resources for those studies. Therefore, they are less likely to get done.

Coordinating/integrating/collaborating was the eighth most prevalent action code and was represented in 18 out of 24 documents. There are many committees established across the legislative documents, such as the Mental Health Medicaid Quality Advisory Committee in Indiana in 2013 and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) in the 21st Century Cures Act, which includes representatives from a variety of agencies within the government as well as representatives outside of the government (e.g., the Executive Director of NMHO National serves on ISMICC). This code also includes any initiatives to incorporate mental health into primary care, which is one goal of the 21st Century Cures Act. These components of the legislation are literally bringing bodies together to address issues, both in terms of collaborative initiatives that require a committee and integrative services that require a variety of medical/health expertise.

Publishing/circulating, the final action code, was the ninth most prevalent and appeared in eight out of 24 documents. It sometimes accompanied evaluating/assessing because the legislation would ask that the findings of a study be published and made available to the public. However, the code was most prevalent in the federal parity acts, as they require insurance companies to make their plan information more readily available to patients, as well as provide reasons for any claim denials. While information is rarely ever physically circulated anymore, it's availability and circulation through electronic means enables people to make more informed decisions, which could then improve their mental health outcomes.

Conclusion

Major Finding 4 reveals how interactions between advocacy materials and legislation lead to material effects on the mental health system in the United States. Advocacy materials compel legislators to revise existing legislation or pass new legislation. The language in that legislation then produces "actions" that have material effects on the mental health system and

individuals living with a mental illness. Those actions include defining, funding, evaluating/assessing, establishing, mandating, restricting/limiting, permitting, coordinating/integrating/collaborating, and publishing/circulating. These categories of language within the legislation lead both governmental and non-governmental entities to focus their time and their actions in particular ways. Who or what gets included and excluded not only signals legislators' values and priorities but also determines who or what gets access to valuable resources that could ultimately improve mental health outcomes. Ultimately, these material effects provide the exigence for studying the interactions amongst advocacy materials and legislation because they demonstrate the consequences and influence of language and media.

4.3 Conclusion

In this chapter, I have presented four major findings, which include the following:

- Despite the prevalence of open communication channels, influence and power within both legislation and the NMHO primarily flow from federal/national to state and local.
- NMHO's advocacy materials are often reactions to legislation and other policy initiatives
- NMHO's advocacy materials impact legislation through direct communication to lawmakers as well as indirect communication from members
- Advocacy materials and legislative documents have material effects on the mental health system in the United States

In Chapter 5, I apply these findings to the theoretical frameworks outlined in Chapter 3. Specifically, I use Assemblage Theory, Rhetorical Ecologies, materialist rhetorics, and Institutional/Organizational Theory to demonstrate how the language used in mental health legislation and advocacy materials serve as "lines of flight" or "flows" that lead to material outcomes. Additionally, I show how some legislative documents and advocacy materials attempt to either territorialise or deterritorialise the mental health system in the United States. Finally, in Chapter 6, I explore the potential implications of these discussions for mental health advocacy organizations, RHM and Rhetoric and Composition as a whole, and professional/technical writing pedagogy.

CHAPTER 5: DISCUSSION

5.1 Introduction

NMHO staff/leadership and legislative officials have values and priorities that are reflected in the documents/media that they produce. These documents/media are circulated in a variety of spaces and often have effects that can't be predicted by the individuals who created them. In the introduction of this dissertation, I mentioned my own lived experience with a mental health condition and my struggles with seeking treatment because of the shortage of mental healthcare professionals in my area. Although it is difficult to pinpoint exactly where and how that problem emerged, we can potentially go all the way back to the Reagan Administration. In 1987, the Omnibus Budget Reconciliation Act (OBRA) repealed the Mental Health Systems Act, which was meant to provide funding directly to community mental health centers across the United States. The OBRA, instead, allocated mental health block grants to each state that were not required to fund community mental health centers, nor were the grants required to target areas that were already underserved. The funding of community mental health centers is an issue that the NMHO, at all levels, has advocated for, and there have been some improvements. For example, the 21st Century Cures Act reinstated funding that is required to go to community mental health centers, as well as funding that incentivizes mental health professionals in training to begin their careers in underserved communities. However, the damage had already been done, and my own lived experience with the mental health professional shortage is just one example of how a document can disrupt an entire system that comprises a variety of entities with varying levels of influence and power.

The NMHO and legislative bodies are each separate entities within this system that have their own unique characteristics within and amongst their various levels. However, the communication that flows amongst them demonstrates how their connections at particular points create affects that reverberate throughout the mental health system. While, in general, the most impactful affects seem to emerge from the federal/national level, the state and local can also assert their influence and create impacts beyond their own levels. Additionally, as time passes, the documents/media and initiatives that seem to exert influence often shift, so it is difficult to pinpoint a central driving force within the advocacy-legislation relationship. Therefore, although

the national, state, and local setup of both the NMHO and the legislation featured in this study may appear to be hierarchies, the findings of this study demonstrate that the relationships among them is much more complex.

In this chapter, I further illustrate the circulation of communication amongst the NMHO and federal, state, and local legislative bodies and the affects that communication has on the mental health system by discussing the findings from Chapter 4 and applying them to Assemblage Theory, Rhetorical Ecologies, Institutional/Organizational Theory, and materialist rhetorical theories. Essentially, I argue that legislation and advocacy materials at all three levels function as a complex, entangled assemblage, with each component producing flows or "lines of flight" that either attempt to stabilize/standardize (*territorialise*) or destabilize/disrupt/expand (*deterritorialise*) the assemblage as a whole. These flows are either *aggregative*, meaning that they have widespread effects across the assemblage, or they are *singular*, meaning that their effects are more targeted at one particular component within the assemblage (DeLanda, 2006, 2016; Deleuze & Guattari, 1987; Fox & Alldred, 2015). My findings suggest that certain components of the assemblage, particularly those at the federal/national level, have more power and influence and, therefore, more significant affects than other components. However, less powerful components—those at the state and local levels—are momentarily able to disrupt the assemblage and create reverberating affects. Furthermore, I discuss how the language used in the document and media circulated by the NMHO and the legislative bodies leads to material effects on the mental health system and can impact the quality and availability of mental health treatment and services throughout the United States.

5.2 The NMHO and Legislation as an Assemblage

The first finding in my Results chapter indicates that influence and power for both the NMHO and legislation are primarily concentrated at the national or federal level and then flows to the state and local levels. From this finding I conclude that certain components of the assemblage, because of their positions as rhetorical subjects, have a greater ability to produce aggregative flows that have significant territorialising or deterritorialising affects across the assemblage.

However, my data also suggests that NMHO and legislative bodies function slightly differently: NMHO as an organization has shared values/priorities and free-flowing

communication among national, state, and local. Although power and influence are concentrated at the national level, state and local affiliates have some ability to make an impact beyond their level, both within and outside the organization. The NMHO is a grassroots organization, but, at the same time, it also must maintain legitimacy and present a coherent, united narrative to external audiences. Hence, there exists a tension between centralized messaging that territorialises the organization's mission, values, goals, and priorities and decentralized communication that highlights individual experiences and addresses state/local issues.

On the other hand, my findings suggest that legislation at all levels primarily territorialises, since its main goal is to regulate and set standards/rules. However, federal, state, and local legislative bodies often have different priorities/values and less open communication channels among them because they are separate entities serving different demographics of people. Since federal legislation encompasses the entire United States, they must take into account competing interests from a number of different regions. States and local regions certainly aren't homogenous, but they do often have unique issues and perspectives that require more localized responses. For example, in part because Indiana is a largely rural state, almost every county experiences a shortage of mental health professionals (Rural Health Information Hub, 2020). The Indiana state government responded by creating a Mental and Behavioral Health Workforce Taskforce to help solve this issue. Yet, there are pieces of federal legislation—namely the 21st Century Cures Act—also aimed at solving mental health professional shortages across the country, and state/local legislators must take these federal initiatives into account when they are building their own legislation. Therefore, my findings also suggest that federal legislation, in particular, acts as a meta-genre that territorialises legislative documents at the state/local level, in addition to the NMHO advocacy materials (Berkenkotter, 2001; Fox & Alldred, 2015).

5.2.1 Communication and Power Flow Throughout the Assemblage

My first major finding demonstrates how communication and power flow throughout the legislative-advocacy assemblage analyzed in this study. Within this section in Chapter 4, I presented two assemblage maps, where each stakeholder/component of the assemblage was arranged and grouped based on the common values/priorities that they shared. One map (Figure 1 in Chapter 4) highlights the communication channels between stakeholders/components

(Figure 2 in Chapter 4) demonstrates the flow of power throughout the assemblage. The components themselves are important because they are "integral to [the assemblage's] existence" (Buchanen, 2015, p. 385)—and I will go into more detail about their structure and function later in the chapter. But, as Nail (2017) points out, what is most significant about an assemblage is the relationships and connections that hold the components together, specifically the lines of communication. Each component has its own autonomy and existence outside of the assemblage, so it is the interactions among them that facilitate the assemblage's emergence (DeLanda, 2016). The values/priorities, communication channels, and power dynamics make up the "network of social and historical processes" that have enabled the assemblage examined in this study to emerge (Nail, 2017, p. 24). For example, the three levels of the NMHO and their members are all connected by a unique "set of relations" (Nail, 2017, p. 24) that bring them all together for the purpose of improving the lives of individuals living with mental health conditions and their families. In other words, they all identify with each other because of shared values and experiences surrounding mental health (Burke, 1969). All NMHO staff and supporters have their own identities outside of the assemblage—and those identities will certainly inform how they interact with other components—but it is the lines of communication among them and the other components of the assemblage, like the three levels of legislative bodies, that keeps the assemblage alive and in a constant state of becoming. We might say that a form of collective identification amongst the components occurs as they are all united through a common purpose (Burke, 1969).

The interactions among the components through acts of communication (i.e. the communications channels indicated on the maps) demonstrate intersections between the material and the symbolic, or machinic assemblages and collective assemblages of enunciation (Buchanen, 2015; Deleuze & Guattari, 1987). The NMHO staff and supporters, legislative officials, the advocacy materials, the legislative documents, individuals living with mental illness, mental health professionals, insurances companies, and myself as volunteer/researcher are all corporeal bodies that interact both physically and symbolically. For example, the reciprocal communication channel between NMHO National and federal legislation/legislators is physical in the sense that they may meet face-to-face, or they may communicate through letters or emails which are both "material" documents. However, those communication channels are also driven by the expressive—the language used in those meetings and documents. Both the

material and the expressive matter in these interactions because who is involved in the interaction (the rhetorical subjects), their position or level of power, and the context surrounding it are what determines the types of statements that can be made (Buchanen, 2018; Foucault, 1972).

This is why, in addition to communication channels, it's important to also examine power dynamics and how power flows throughout the assemblage. As Figure 2 in Chapter 4 illustrates, power flows differently within the NMHO and the different levels of legislative bodies than it does between the two. Power primarily flows from national/federal to state and then to local within the two types of organizations/institutions. Power also seems to flow from federal legislation to NMHO Indiana and NMHO Local, and from Indiana state legislation to NMHO Local. However, there is more of a reciprocal power dynamic between federal legislation and NMHO National, state legislation and NMHO Indiana, and local legislation and NMHO Local. I say that power "flows" among the components in the assemblage because their interactions make up a system of statements or "discursive formations" that get circulated through various forms of communication (Buchanen, 2018; Foucault, 1972).

Although an assemblage does not technically have a center or a primary component that controls all the others, there are components that, at particular times—because of the spaces that they occupy as rhetorical subjects—have more ability to produce aggregative flows that have greater territorialising or deterritorialising effects on the assemblage as a whole (Fox & Alldred, 2015; Greene, 2009). For example, when one NMHO staff member, like Donna, goes into a meeting with a legislative official, she can communicate on either a microrhetorical or sociorhetorical level: microrhetorical in the sense that she is an individual speaking one-on-one with another individual and describing her own personal experiences; sociorhetorical in that she and her viewpoint are also representative of the NMHO's mission. However, legislation and policy communicate on a macrorhetorical level because they are representative of institutions whose values and norms are entrenched in all levels of society (Baba et al., 2012; Hodgson, 2006; McGee, 1982, 2009). Individual people, organizations, and institutions have differing levels of power and abilities to circulate communication and enact change.

5.2.2 The NMHO's Distributed Communication and Power Structure

The different levels of the NMHO are united as an organization, but the flow of communication and power is more distributed and complex. As stated in Velut (2013), advocacy organizations—during the emergence of social media and other digital technologies—have become simultaneously more centralized and decentralized. Organizations can use the Internet and social media to promote a coordinated, national-reaching message while at the same time encouraging individual members who may be involved with state or local affiliates to share their own stories and promote causes that directly affect the region in which they live. The interactions among these centralized and decentralized texts can be described as NMHO's "network of communication episodes" that include statements representative of the entire organization's views, as well as those pieces of communication that occur at the micro level from individual people within the organization (Blaschke et al., 2012, p. 881). For instance, as shown in the previous chapter, NMHO National has published a number of blog posts that promote a stance about a mental health issue and then asked their members to share their own experiences related to that issue in the form of a tweet or other type of social media post while using a particular hashtag. In these cases, NMHO is coordinating a singular organizational message, which serves to centralize and unite the organization, while at the same time allowing members to participate in the way the message is expanded and spread, which is a form of decentralization.

Furthermore, these organizations often store information and materials in one centralized, digital location for members to access. NMHO National has a central location within their website where members and state/local leaders can log in and find various resources to help them facilitate activities and advocacy initiatives. Additionally, within this space, there are guidelines for using language and organizational branding, as well as governance documents that include articles of incorporation, bylaws, policies and procedures, a strategic plan, and a mission statement. These types of documents enable organizations like the NMHO to build their legitimacy and identity, as they are often required by law in order to even be officially recognized as a formal organization. These documents communicate the organization's values and priorities in order to set them apart from others, but they are also "embedded in a wider societal context" as they must follow templates and guidelines set forth by macro level institutions that regulate how organizations can function in that context (Blaschke et al., 2012, p.

883). This interaction with institutional messages is yet another piece of the rhetorical puzzle in which organizational messaging emerges.

One aspect of the governance documents that I highlight in the previous chapter is the mission statement. NMHO National, NMHO Indiana, and NMHO Local all have slightly different mission statements that highlight the particular purpose that they served at their level (e.g., support, training, education, etc.). However, all three statements clearly follow language and guidelines set forth in the bylaws, articles of incorporation, and other organizational guidance documents published within that central database on NMHO National's website. Requiring all state and local affiliates to follow these guidelines and governance documents—while at the same time allowing them the freedom to tailor them to their local or regional needs—demonstrates the push and pull between the organization's need to maintain order while allowing the individual and group "actors" who make up the organization the freedom to enact change and shape the organization to serve their needs (Baba et al. Adams, 2012). In other words, although the bylaws and mission statement territorialise all levels of the organization by standardizing their purpose and goals, state and local organizations can deterritorialise using those same documents by adapting them and repurposing the mission in a way that NMHO National could not have envisioned because of their limited contact with local communities.

Furthermore, the original blog posts that NMHO National publishes on their website may be sending out a highly intentional message about the organization's stance and how they believe external forces like governmental bodies should react. However, by encouraging members to more broadly share and add their own commentary to that message, they are allowing that message to take on a life of its own in order to increase its reach, frequency, and endurance as it gets circulated to a wider variety of audiences within digital spaces (Lammers, 2011). In this case, NMHO National is attempting to deterritorialise some aspect of mental health legislation or policy while territorialising the stance of the organization. But members and supporters who share the post along with their own message are producing lines of flight that disrupt and adapt that original message, thereby expanding the assemblage in ways that NMHO National could not control or anticipate.

As a grassroots organization, it's important that NMHO allow the state and local affiliates to directly communicate with the national organization and provide their input on the organizational initiatives and goals. This is how the NMHO maintains its legitimacy within the

organization. However, it must also seek and establish legitimacy with those outside the organization, so it must be able to demonstrate "the performance of a stable identity over time" and present a solid organizational narrative (Clegg et al., 2007). This pressure of external legitimacy may be one reason why NMHO National territorialises the organization's advocacy initiatives and creates a majority of the advocacy materials and templates, like the advocacy guide for first episode psychosis programs. However, because they must still maintain internal legitimacy, they also encourage state and local affiliates, as well as individual members, to personalize those materials based on their local contexts.

We also see the NMHO attempting to create this narrative through their public policy platform and dedicated public policy section on their website. The platform document, as well as the section of the website, serve dual purposes and are intended for two separate audiences: NMHO leadership at the state and local level and the general public. They are presenting this narrative internally so that state and local leaders understand the organization's priorities and are able to successfully implement them into their own initiatives. At the same time, they are presenting the same narrative externally to build legitimacy and potentially expand the organization by attracting new members or garnering support from like-minded outsiders who may have the means to help the movement on a broader, more systemic level. They, therefore, are creating the potential for interactions with other entities in order to foster change and coalition-building (Baba et al., 2012).

Furthermore, they are establishing a logic that the organization can follow and that is encoded and dispersed throughout the texts published and circulated at national, state, and local levels (Brown et al., 2012). The public policy platform and the public policy section of the website establish advocacy priorities for the entire organization, and the most common topics addressed throughout the documents at all three levels—mental health reform, funding of mental health research and programs, early intervention/diagnosis for better treatment outcomes, integrated care, and criminal justice—are all priorities named in that central location. In this case, the public policy platform document and the website published by NMHO National are producing aggregative flows that territorialise the organization, as the platform is meant to "stabilize" and "systematize" the organization's viewpoints and how they respond to outside influences like governmental bodies (Fox & Alldred, 2015).

However, as explained in the Results chapter, although power does primarily flow from the national level, there are several notable exceptions where NMHO Indiana and NMHO Local determine their own priorities and are able to affect change within the organizations beyond their own level. For example, the white paper on the mental health workforce shortage written by Donna, former Executive Director of NMHO Local, was circulated widely amongst local, state, and national leaders and produced a material impact by providing evidence for a problem that effects not only the county addressed in the paper, but the entire state of Indiana. The evidence was used both within the organization (in an issue of NMHO Indiana's newsletter) and outside the organization (in Indiana's Mental and Behavioral Health Workforce Taskforce). Therefore, we can say that the white paper and NMHO Local produced a singular flow that deterritorialised, as it created a disruption that generated content and action both within and outside the organization but did not necessarily lead to significant systemic change. Nonetheless, it did also most likely cause some reterritorialisation within the assemblage to correct the perceived problem on a wider scale, which is evidenced by the state government's response in creating a taskforce to increase the number of mental health professionals in the state.

We see something similar occur when NMHO National highlights an accomplishment by a state or local affiliate, or when they publish a piece of content written by a member or leader at one of those affiliates. It's unclear whether the state or local affiliates submitted those accomplishments or pieces of content of their own volition, or if NMHO National asked for them specifically. Either way, in those instances, we can argue that the state and local affiliates are also producing singular flows that deterritorialise NMHO National's advocacy strategy because they are shifting attention from national efforts to advocacy happening in state and local contexts. Also, highlighting successes and what's working at state and local levels may lead to changes in priorities at the national level. For instance, NMHO National uses the crisis intervention legislation passed in Indiana as an argument for the support and funding of CIT programs at the federal level. In this sense, NMHO Indiana is able to transcend their own level and make a broader impact.

5.2.3 Legislation's Disjointed Communication and Power Structure

Legislative bodies function differently than nonprofits because they are more like institutions than organizations. While institutions do enact change, they are most often associated

with producing regulations and order. Furthermore, institutions exert power and control across macro, meso, and micro levels—with macro representing society as a whole, meso representing large groups/organizations, and the micro representing individuals or small groups (Blaschke et al., 2012; Cloutier & Langley, 2013; Spinuzzi, 2003). Although they may not be an exact parallel, in the context of this study I roughly translate macro, meso, and micro to national, state, and local. In the case of legislative bodies, federal legislation functions at the macro level because it is meant to maintain order and regulate society across the entire United States. Indiana state legislation functions at the meso level because it regulates citizens and organizations within the state of Indiana, and local legislation functions at the micro level since it applies to a smaller area and fewer people. All three levels are a part of the same institution (government), but they are separate entities that have varying levels of power over different types of organizations and people. As government institutions, legislative bodies at all three levels are attempting to territorialise individuals and organizations in their jurisdiction because the ultimate goal of legislation is typically to establish rules and regulations and control behavior and resources (Hannah, 2010; McNely & Rivers, 2014). As separate entities, state and local legislative bodies can pass legislation that they believe will best maintain order and address the needs of their specific constituents. For instance, because the rate of opioid overdoses is much higher in Indiana than the rate at the national level, the Indiana General Assembly has produced more legislation aimed at controlling the situation and that attempts to territorialise the responses and behaviors of the criminal justice systems, organizations that provide treatment and recovery resources, and the opioid users themselves.

Federal legislation in particular has the power to territorialise not only individual citizens and organizations across the United States, but also other legislative bodies at the state and local level. One example of this is the Affordable Care Act (ACA), which required states to write new legislation that fundamentally changed their own healthcare systems. One provision within the law gave states the choice to either expand the threshold for who qualifies for Medicaid or create their own programs that would cover individuals within a certain income range. Although states did have a choice in how they responded, they couldn't choose to *not* respond. They had to act in one of two ways. Indiana chose to create the Healthy Indiana Plan instead of expanding Medicaid. In this case, we can argue that this choice deterritorialises the influence of the federal government on the state of Indiana because they are establishing and running their own program.

Yet, that program still has to follow certain guidelines set forth within the ACA, so another perspective would be that this portion of the ACA represents an aggregative flow that territorialises the responses and the legislation/policies implemented by state and local governments.

Furthermore, because, in this case, the ACA serves as "a mediational means or tool for stabilizing practices" by requiring state and local legislative bodies to write more legislation that enables their jurisdiction to comply with the rules, we might classify it and other forms of comprehensive legislation as "meta-genres" (Berkenkotter, 2001, p. 339). In this example, the ACA is functioning much like how Berkenkotter (2001) characterized the *DSM*, which she found led to new forms of paperwork and changes in diagnostic and prescribing practices at a mental health clinic. We see a similar phenomenon with one of the provisions in the 21st Century Cures Act: the Community Mental Health Services Block Grant. In this case, the territorialising affects occur all the way down to the local level. The grant is provided to states each year, and they are required to use it to fund community mental health centers, which are typically controlled by county or city/town officials. In the state of Indiana, the funds that are received are passed down to local governments, and, according to the Indiana Code, they are each required to use those funds for their local community mental health center. Therefore, every year, the local government featured in this study passes a new resolution that renews funding for the community mental health centers located within their county. So, in this example, the 21st Century Cures Act—which is a piece of comprehensive mental health legislation—has become a meta-genre that was the impetus for that particular section of the Indiana Code as well as the yearly resolution at the local level. The Cures Act is also a stabilizing factor in terms of the material existence of the community mental health centers—i.e., without the block grant that flows all the way to the local, the centers may not be able to function efficiently, if it all. I will further explore this relationship between the symbolic and the material later in this chapter.

5.2.4 The Interactions Between NMHO and Legislation

While there is minimal communication amongst the different levels of legislative bodies within the United States, legislative officials at all levels must keep open lines of communication with the individuals and organizations that they serve. Therefore, as shown in the previous chapter, NMHO and its leaders/members at all three levels are able to directly share their

perspectives with legislators through acts of communication at both the micro (individual) level and meso (organizational) level. Particularly at the national and state levels, individual documents such as letters, emails, reports, one-pagers/white papers, fact sheets, amicus briefs, and written or verbal testimony are presented or written by individuals or groups of individuals within the organization, but they are typically representative of a broader communication strategy that conveys the organization's viewpoint. NMHO National is most concerned with federal legislation, NMHO Indiana with Indiana state legislation, and NMHO Local with local legislation. Nonetheless, because they are still a united organization with a shared mission, one aspect of that broader strategy is staying informed about what's happening at other levels and providing support when necessary. For instance, although NMHO National staff members rarely communicate with state or local elected officials, they provide the tools for NMHO state and local organizations to more readily do so. These tools then empower individuals to reach out and directly communicate with elected officials. One of the best examples of this phenomenon is Hill Day hosted by NMHO National. This event enabled Donna and Lucinda to speak with Indiana's U.S. Senators. Donna was particularly successful because she was able to directly hand her white paper to both Senator Donnelly and Senator Young. It is through this interplay between individual, micro acts of communications and broader, meso communicative strategies that the NMHO is able increase the reach and endurance of their message and in turn drive institutional change (Dacin, et al., 2012; Lammers, 2011). Additionally, Hill Day enables NMHO members to subvert the perceived hierarchy within the assemblage, as "lower level" staff members in NMHO are able to communicate directly with federal legislators.

5.2.5 Conclusion 1: Mental Health Legislation and Advocacy Function as an Assemblage

In sum, this finding demonstrates how mental health legislation and advocacy function as an assemblage. Although the NMHO and the different levels of legislation may appear hierarchal on the surface, the way that documents/media and communication circulate and interact suggests that relationships amongst the components are much more entangled and complex. While certain components—namely those at the federal/national level—do have a greater ability to produce aggregative flows that produce affects across the assemblage, there are moments where a piece of document/media from the state or local level is able to deterritorialise and disrupt the assemblage. These documents/media most often come from NMHO Indiana and NMHO Local,

as the NMHO's grassroots structure enables and welcomes input from members and "lower level" officials. However, the NMHO must also present a coherent, united narrative to maintain external legitimacy, so there is a tension between centralization and decentralization.

On the other hand, legislation at all levels primarily territorialises the assemblage because its main purpose is to regulate and standardize. But federal legislation in particular also acts as a meta-genre that generates new or revised legislative documents at the state and local level. In the following section, I build on this assertion and demonstrate how legislation at all levels can be characterized as "charter documents" within the mental health system, since they heavily influence the advocacy materials that the NMHO produces.

5.3 Legislation Territorialises the NMHO's Advocacy Materials

The second finding in my Results chapter demonstrates how NMHO's advocacy materials are often reactions to legislation and other policy initiatives. Namely, the topics that NMHO addresses in their advocacy materials reflect the subject matter covered throughout the mental health legislation within the dataset. Furthermore, the NMHO spends a significant amount of time/space throughout their advocacy initiatives either supporting or condemning various legislative acts. Based on this finding, I conclude that legislation functions as a charter document within the mental health system, since it appears to be the impetus behind much of the advocacy materials created by the NMHO (Markel, 2010; McCarthy, 1991, 1992, 1994). Reynolds (2017) characterizes a charter document as one which defines "certain ways of seeing, deflecting attention from other ways, stabilizing a reality, setting the terms of/for future discussions" (p. 7). In other words, a charter document dictates the norms, values and actions of a community or field of study, thereby influencing future acts of communication that occur among the actors who participate in that particular system. The mental health legislation cited in this study shapes NMHO's communication by essentially providing the exigence for their advocacy and a majority of the materials that they create.

5.3.1 Legislation as Charter Documents

Two pieces of legislation that seem to have an overarching influence over the advocacy strategy at all levels of the NMHO are the Affordable Care Act (ACA) and the Mental Health

Parity and Addiction Equity Act (MHPAEA). The ACA and the MHPAEA stand out because they led to significant changes in the infrastructure of health insurance in the United States, namely banning insurance companies from denying coverage or raising premiums because of pre-existing conditions, requiring that health insurance cover some essential health benefits (one of those being mental health), and obligating parity between coverage for both physical and mental health. They also dominated media coverage and legislative priorities concerning healthcare for years on end because, although the MHPAEA and the ACA were passed in 2008 and 2010, respectively, the MHPAEA was not finalized until 2013, and many of the provisions in the ACA did not take effect until 2014. Furthermore, there was a concerted effort by conservative legislators to repeal the ACA in 2017 through the American Health Care Act, a move which received intense backlash from the NMHO and similar organizations whose members would have been negatively affected by its passing. Because the futures of the MHPAEA and the ACA were (and still are) precarious, these pieces of legislation have remained a high concern for the NMHO and have therefore produced an aggregative flow that continues to territorialise their advocacy priorities. In fact, the ACA is the most mentioned legislation across all materials in the dataset (spanning from years 2010 to 2019) as well as across all three levels.

Another prominent example at the national/federal level involves the companion bills, the Helping Families in Mental Health Crisis Act in the House of Representatives and the Mental Health Reform Act in the Senate. In response to those bills' introductions to Congress, the NMHO wrote letters to Congress to support them, explained their significance and encouraged their members to support them using blog posts and news articles, and made appearances on C-SPAN to advocate for some of the provisions within the bill. Additionally, after the bills were passed as a part of the 21st Century Cures Act, the NMHO produced even more content that celebrated the new law. One way that we might categorize these advocacy materials is by labelling them as "subsidiary texts" since they summarize, analyze, and critique mental health legislation (Markel, 2010). Markel (2010) argues that subsidiary texts play a crucial role in influencing legislative charter documents because they reach a variety of audiences and therefore shape the opinions of not only elected officials but also other stakeholders, like their constituents or mental health professionals. Swaying a significant number of people could then impact the language used or the types of provisions included in a piece of legislation—in addition to whether or not it would receive sufficient support to receive arguments and eventually become

law. Later in the chapter, I will argue that advocacy materials as subsidiary documents do in fact influence legislation. However, in this case, the opposite is true: the charter documents (the two companion bills and 21st Century Cures Act) have produced an aggregative flow that territorialises the NMHO's advocacy strategy. Because these bills made mental health reform seem possible after years of inactivity from Congress, reform became the focus of their advocacy in 2015, 2016, and 2017.

We see something similar occurring at the state level in terms of crisis intervention. In 2015, the Indiana General Assembly passed P.L. 115 which created the Indiana Technical Assistance Center for Crisis Intervention Teams. In the lead up to its passing, as well as after it was signed into law, NMHO Indiana published several documents describing the contents of the legislation as well as encouraging their followers to contact their elected officials and show their support. The number of NMHO Indiana documents that directly mention the crisis intervention legislation is much lower than the number of NMHO National documents that directly mention the 21st Century Cures Act. However, since NMHO Indiana produces significantly fewer documents than NMHO National, the representation is still meaningful and demonstrates another example of an aggregative flow territorialising NMHO materials. Furthermore, as indicated in the previous chapter, criminal justice—which is directly tied to crisis intervention services—is one of the most common topics addressed on NMHO Indiana's web pages, which have no date tied to them but are available for the general public to view at any time. This suggests that while legislative documents territorialise from within the assemblage, the components also must respond to the external issues and events that initiate the need for legislation and advocacy.

The best example of this phenomenon within the dataset involves the relationship between gun violence and mental illness. Violence isn't a prominent topic across all the NMHO documents in the dataset. However, after two high profile mass shootings—Sandy Hook and Aurora—took place in 2012, there was a clear spike in the amount of time/space that the NMHO spent on debunking myths about mental illness and violence, because citizens and lawmakers began making public calls for stronger mental health legislation following the events. This spike occurred once again in 2016 when President Obama announced an initiative to increase mental health funding in order to combat gun violence. In both of these cases, it is not a single document that territorialises, but instead a collection of thought and conversations surrounding a particular issue. We could even say that the association between mental illness and gun violence has

become a sort of "institutional logic" in the United States because that particular narrative is so entrenched within society through its circulation in popular media (not only through news sources but also in entertainment, such as with the 2019 *Joker* movie starring Joaquin Phoenix) and in discourse surrounding policy and legislation.

These examples demonstrate how legislative documents—and the issues/conversations that surround them—are territorialising "troublemakers" that have the power to "authorize, allow, afford, encourage, permit, suggest, influence, block, render possible, [or] forbid" and then, in turn, "significantly shape communication" (McNely & Rivers, 2014, pp. 1-2). The comprehensive pieces of legislation, like the ACA, MHPAEA, and the 21st Century Cures Act, set a precedent for healthcare legislation as a whole and also provided the NMHO with a sort of "baseline" of expectations for governmental interventions in mental health care. Because all three documents were so significant—and because their failure to pass or to not include certain provisions would have been massive blows to the mental health community—they more or less dominated NMHO National's advocacy strategy in the years leading up to their passing and their final rules taking effect. Furthermore, their passing "rendered possible" major healthcare reform, which, in turn, "encouraged" the NMHO to keep pushing and asking for more. The same phenomenon occurred at the state level before, during, and after P.L. 115 was signed into law. In fact, NMHO Indiana had to continue their advocacy efforts in relation to that law because while the original legislation passed in 2015 did establish the Indiana Technical Assistance Center for Crisis Intervention Teams, it did not fund the center. It wasn't until 2017 that the Indiana commission designated a grant for the center through P.L. 102. Therefore, while P.L. 115 "allowed" for a technical assistance center, there was no money to actually build the infrastructure and get the center up and running. This then affected NMHO Indiana's advocacy strategy because they had to both show their support and praise the law for authorizing the center, but at the same time condemn it for its lack of funding.

5.3.2 Conclusion 2: Legislation Primary Territorialises Within the Assemblage

According to DeLanda (2016), assemblages are always in a state of emergence, which means that there is a constant push and pull between territorialising forces wanting to stabilize and standardize and deterritorialising forces attempting to change or re-invent the assemblage. Legislation's influence on the NMHO's advocacy initiatives demonstrates its role as a

territorialising force aiming to monitor, coordinate, and govern the mental health system in the United States. Yet, as the next section demonstrates, NMHO's advocacy materials are also capable of disrupting the assemblage and shaping legislation in order to provoke institutional change.

5.4 NMHO Advocacy Materials Aim to Disrupt and Deterritorialise Legislation

The third finding of this study was that the NMHO's advocacy materials impact legislation in two different ways: 1. Through direct communication with lawmakers using written or verbal testimony, reports, letters, amicus briefs, white papers, and one-pagers, and 2. Through indirect communication in the form of advocacy materials—such as blog posts, news articles, press releases, newsletters, and web pages—targeted at their membership base and the general public. The latter aims to educate the public about mental health issues and get them to act by participating in events or contacting their elected officials about particular initiatives.

My major conclusion for this finding is that both types of documents—those aimed directly at lawmakers and those targeted towards members and the general public—are attempting to incite "deinstitutionalization," or institutional change, in the mental health system (Brown et al., 2012; Dacin et al., 2002). In other words, they attempt to deterritorialise the system by shifting the perceptions of lawmakers and the general public and, in turn, legislative priorities. They accomplish this objective primarily by pointing out problems or "functional issues" within the current system but also by attempting to create a shift in political priorities and in the values of lawmakers, members, and the general public by educating them on the issues that people with mental health conditions and their families face (Dacin et al., 2002). With their advocacy materials, the NMHO is presenting a "selection of reality" by focusing on the problems and providing a potential alternative that then deflects from the reality of the current system and allows their audiences to imagine something better (Burke, 1966, p. 45). Their selections of reality produce lines of flight or "flows" that first deterritorialise by pointing out flaws in current mental health policy. Then, they attempt to reterritorialise by illustrating the possibilities of a better mental health system in the United States. These lines of flight are a combination of singular flows produced by individual documents and aggregative flows produced by sets of documents as part of a coordinated strategy to address a particular issue. The singular flows cause their readers to think differently about an issue and then act in a particular way while the

aggregative flows attempt to shift societal values and drive institutional change. Ultimately, they are attempting to foster identification amongst their readers so that they will unite behind a common narrative and common values (Burke, 1969).

5.4.1 NMHO Deterritorialises Using a Coordinated Strategy Across Documents

As my findings demonstrate, the NMHO develops a variety of materials addressing the same problem that are geared toward different audiences. For example, in 2017, NMHO National wrote a letter addressed to Speaker Paul Ryan, Minority Leader Nancy Pelosi, Majority Leader Kevin McCarthy, and Minority Whip Steny Hoyer condemning the AHCA and urging them not to allow the legislation to move forward. Additionally, NMHO National also published several blog posts that explained why the AHCA would be detrimental to individuals with a mental health condition and encouraged them to oppose it as well. Although documents like the AHCA letter are created specifically for lawmakers, they are made available for members of the general public to read. This is yet another way that the NMHO builds their legitimacy both internally and externally (Alvesson, 1993; Berger & Luckman, 1966). By maintaining transparency with their members and the general public, they build trust and strengthen bonds with supporters. This trust and transparency then also become a part of their identity as they present themselves to the broader public.

The NMHO's identity as an organization is reflected in their advocacy initiatives and the materials they produce, which also generates institutional change and deterritorialises the current mental health system. Each document or piece of media published and circulated by all levels of the NMHO produce singular flows that have a deterritorialising effect on other documents within the assemblage represented in this study, as well as the thoughts and actions of lawmakers, members/supporters, and the general public. As demonstrated in the Results chapter, the most common strategies that the NMHO used to deterritorialise the system through their advocacy materials were "calling for action," "pointing out a problem," and "educating or informing." In a sense, it is difficult to separate the three strategies because they often go hand-in-hand (the NMHO would point out a problem or educate/inform with the hopes that whoever read the document would act in a particular way). However, the goal of the latter two ("pointing out a problem" and "educating and informing") is to disrupt or change thought processes about

particular issues, while the goal of "calling for action" is to induce action that would then disrupt or change the mental health system.

The NMHO uses two primary rhetorical strategies to deterritorialise thought and perceptions surrounding issues related to mental health: 1. Providing facts/evidence, and 2. Citing individual's personal experiences with mental illness. In documents targeted toward lawmakers and those targeted toward members/the general public, the NMHO would most often use a combination of both strategies in order to convince readers to care about an issue or adopt a particular viewpoint. For example, in the parity report for lawmakers referenced in section 4.2.3 in Chapter 4, a statistic on the number of veterans/active duty service members who have experienced mental health symptoms is featured on the same page as a quote from an actual 911 Call Center Counselor, who had taken a call from a veteran who expressed a desire to walk into traffic and "end it all." Similarly, in a blog post geared toward NMHO members and the general public, they provide a statistic about the high levels of unemployment amongst veterans in the same paragraph as a personal story from a combat veteran who was struggling to stay mentally healthy and find a job.

This juxtaposition of the statistical with the personal, or the "big picture" with the individual, is the same strategy identified by Brown et al. (2012) in the Australian Senate Committee report on aged care. Employing this strategy illustrates both the breadth and the human side of an issue. Facts/evidence (reason-based arguments or *logos*) exhibit how common and widespread mental health conditions are in specific populations, while personal stories (narrative-based arguments or *narratio*) put a face to the issue and demonstrate how deeply mental illness can impact an individual's life. Individuals with lived experience are key stakeholders for mental health advocacy campaigns because they provide an emotional connection to the issue and allow politicians to envision what it would be like for themselves or one of their family members to struggle with mental illness (Carr, 2014). Their stories also serve as terministic screens that direct attention toward a particular interpretation of a mental health experience that affect the people who hear these stories. The targeted audience will ostensibly form attitudes not only about the person telling the story but also about themselves and their loved ones who they then suddenly see through the lens of another. These terministic screens affect other elements in the assemblage because they force readers/listeners to take other perspectives and consider the possibilities of a different reality with improved mental health

services and outcomes. In other words, they frame issues in ways that force readers to identify with particular positions, which then shapes the flow of information and communication in the assemblage (Burke, 1966, 1969).

Moreover, as Carr (2014) points out, "credibility, trustworthiness, and the status of the persuader" as well as "a broad-based coalition of stakeholders … with a unified message" are also important components of successful advocacy initiatives (pp. 873-874). The facts/evidence that the NMHO collect are one way that they establish their credibility with lawmakers, but they also attempt to increase their status in other ways, such as by partnering with medical professionals, celebrities, and other organizations that perform similar work. The quarterly magazine that NMHO National publishes often features articles written by medical professionals or interviews with top elected officials such as past United States presidents and surgeon generals. It also often features celebrities who serve as ambassadors for the organization and use their fame as a platform for an issue important to them. Additionally, many of the campaigns and lawsuits they have been involved with were in collaboration with other organizations—some of which are also mental health organizations and others that focus on other types of health conditions. Utilizing these stakeholders with varieties of experience and knowledge allows the NMHO to present their arguments about the issues from different angles and demonstrate the consequences of legislation that lawmakers may not have previously considered due to their limited knowledge and viewpoints.

The organization's credibility is what allows them to not only shape thoughts and perceptions but also get lawmakers and members/the general public to act. For lawmakers, these actions include voting in a particular way on a proposed bill, revising a provision in an existing legislative document, providing more funding, and instigating collaboration among governmental agencies. For members and the general public, the NMHO is concerned with getting people to share their personal stories (which would then produce more material for their advocacy initiatives), contact legislative officials, or participate in events that aim to raise awareness about mental health issues. As mentioned previously, the NMHO's depiction of the United States' mental health system and the rhetorical strategies that they use in their advocacy materials function as terministic screens that direct attention in particular ways. More specifically, when they are attempting to shift people's thoughts and perceptions in order to get them to act, they are using what Burke (1969) calls "dramatistic language," a type of terministic

screen that—in addition to directing attention—affects the lawmakers and supporters within the assemblage and compels them to act.

In some cases, the language that the NMHO uses to compel action is pointed and direct: they ask lawmakers to vote in a particular way on a bill or increase mental health funding; they ask supporters to contact their representatives or to tweet with a particular hashtag. But, in other instances, the language is more coded and instead attempts to induce action through changes in thought and attitude. For example, one way that the NMHO "educates and informs" its members and the general public is by summarizing and essentially translating pieces of mental health legislation that are too lengthy and complex for most people to understand. These advocacy materials—which are most often blog posts or press releases—are presented as informative resources, but they often reveal something about the legislation that would either positively or negatively affect individuals who are likely to read the NMHO's content. They present a potential reality to the reader if the bill were to either become law or not become law. Therefore, even language that is designed to inform can be persuasive and then compel them to act in a number of ways, whether that's sharing the information with others, calling or writing their representative, allowing their own story to be included in an upcoming document, or speaking directly to legislators at a hearing or advocacy event.

5.4.2 Conclusion 3: NMHO Advocacy Materials Produce a Combination of Singular and Aggregative Flows that Primarily Deterriorialise the Assemblage

All these forms of direct and indirect communication with lawmakers demonstrate the role that the NMHO plays in impacting legislation. Earlier in the chapter, I referenced Markel (2010), who examines the subsidiary documents that influence legislative charter documents. Markel found that there were many different types of documents created by non-government-affiliated stakeholders that influenced health IT privacy policy. My study illustrates a similar phenomenon occurring with the NMHO's advocacy materials. The documents sent directly to lawmakers direct their attention to how their legislative actions alter entire populations of people and therefore put pressure on them to prioritize mental health in their decision-making. The documents geared toward members/the general public encourage them to reach out and share their stories with lawmakers in order to put a face to the issue and get them to identify with members of the affected populations (Burke, 1969). When we consider each document

individually, they all produce their own singular flows that deterritorialise by causing their readers to think differently about an issue and then act in a particular way. When we consider sets of documents as a part of a coordinated strategy to address a particular issue, then those documents produce aggregative flows that deterritorialise by shifting societal values and driving institutional change. It is a combination of those two types of flows that leads to actions that cause the assemblage to evolve or expand.

5.5 The Flows of Power and Communication Amongst Legislative and Advocacy Documents Have Material Effects

The final conclusion of my dissertation study is that both the advocacy materials and the legislative documents have material effects on the mental health system in the United States. I found that both types of documents used language that generated action in some form. Those actions, in turn, impact mental health outcomes and lead to changes in the system. Namely, NMHO's advocacy materials are created as part of a coordinated strategy—or rhetorical ecology—to shift the public's perceptions and induce them to put pressure on lawmakers. The language used in legislation, on the other hand, generates particular actions—like establishing a new program or providing funding for an initiative—that alter the assemblage in a material way, such as by bringing bodies together or providing treatment to people who previously did not have access. However, those actions are not always successful, and other components in the assemblage, such as health insurance companies, can thwart those actions and inhibit the assemblage from growing or evolving.

5.5.1 The Circulation of NMHO Advocacy Materials Deterritorialises Legislation

The advocacy materials that NMHO circulates induce their supporters and the general public to act in particular ways. As mentioned in the previous section, those actions are typically contacting representatives, providing testimony or stories about mental illness, signing a petition, sharing on social media, or participating in an event. Those actions then put pressure on lawmakers and will hopefully have a positive impact on legislation. Both April and Ben from NMHO National indicated that it's difficult to gather precise data about the impact their advocacy has on legislation because of the length of time that it takes legislation to pass, and because they are not the only mental health organization advocating for the same causes.

However, a study conducted by an outside firm found that the NMHO has significant name recognition and influence in the field of mental health, and April recalls a specific example where she knows they were successful in advocating for a 10% increase in the budget for early psychosis programs (Personal communication, November 9, 2018). This success was the result of a coordinated strategy that involved a press release to alert members and the general public, a fact sheet provided to congressional officials, and an individual with lived experience who provided verbal, in-person testimony.

In their advocacy materials, the NMHO typically use a combination of two rhetorical strategies: 1. They will sometimes first attempt to persuade in more subtle ways by equipping readers with knowledge about mental health conditions and the individuals diagnosed with them (i.e. facts/statistics and personal stories); 2. Or they will directly educate readers about the problems within the mental health system and how they can be addressed through legislation/policy. They will then often end by making direct statements that tell people what they should do with the information that they received (i.e., "Contact your representatives" or "Vote yes to move forward with this bill"). In both of these strategies are attempts to "change reality through the mediation of thought and action" (Bitzer, 1968, p. 4). The ultimate goal is to improve the material realities of individuals with mental health conditions through the passage of effective policy and legislation, and the first step in doing that is through language that convinces people to consider mental health issues in a particular way and then act on their thoughts.

Something important to note as well is that the individual materials themselves do not exist in a vacuum and they are not created independently of each other. Each blog post, letter, report, testimony, etc. exists in a rhetorical ecology that has emerged through a set of historical and social processes that are constantly circulated throughout all the materials (Chaput, 2010; Edbauer, 2005). This ecology is what constitutes the NMHO as an assemblage: these materials occupy a similar space, which allows them to speak with a somewhat unified voice on complex matters. One way to think about this is through the NMHO's ethos and identity as an organization. While it's no Red Cross, the NMHO does have significant name recognition when it comes to mental health, and that ethos—which they have built over time by increasing membership and running campaigns that have caught the attention of significant stakeholders in politics and elsewhere—enables them to make requests of both their supporters and elected

officials. Furthermore, because of the reputation that the NMHO has built, those same people will more likely trust that the information provided in their advocacy materials is accurate.

Additionally, these materials often directly link to or reference each other, and are created as part of coordinated strategies to tackle particular issues. We can use the 10% budget increase as one example: They approached the issue from multiple angles by alerting the public through a press release (which puts added pressure on legislators) and by demonstrating to officials how a budget increase would lead to large-scale improvements in mental health outcomes as well as help individuals on a personal basis. The NMHO has taken similar approaches with countless other issues and pieces of legislation, like with their efforts to block the AHCA or with the new guidance about HIPAA and mental health privacy (both which involved a combination of blog posts, press releases, letters, and testimony). From one perspective, we could say that each of these documents are producing singular flows that deterritorialise one aspect of the assemblage and affect various components. For instance, the press release advocating for the budget increase produces a singular flow that affects the public's perceptions and opinions about early psychosis programs while the fact sheet affects elected officials' opinions using logic and the testimony affects using emotion. However, we can also say that the interactions among these documents as they are circulated simultaneously in these different spaces creates an aggregative flow that deterritorialises the early psychosis budget but also reterritorialises—because the coordinated, yet dispersed, effort succeeded in elevating the NMHO's status and enabling them to take over "space" within legislative conversations and produce affects that influence lawmakers.

5.5.2 Legislation Territorialises Mental Health Treatment/Services and Outcomes

In terms of legislation, my findings suggest that the language used within legislative documents generates particular actions that then have material effects on the mental health system and the treatment/recovery of individuals living with a mental illness. Those actions included the following: defining terms, criteria, or eligibility requirements; funding grants, programs, organizations; evaluating/assessing the success of a program or the need for an intervention; establishing new programs, organizations, or groups; mandating that something be implemented or a procedure be followed; restricting/limiting something; permitting something; coordinating/integrating/collaborating between agencies or health services; and publishing/circulating information or a document.

First, the act of defining has particular rhetorical and material effects. Earlier in the chapter, I described the NMHO's attempts at inducing action as "dramatistic" language, one type of terministic screen as identified by Burke (1966). The second type is "scientistic" language which is concerned with defining what something is or isn't. A definition inherently includes and excludes because it calls attention to something while at the same time diverting attention away from something else. It also affects how people perceive something, as well as how things are organized materially. For example, in a majority of the legislative documents in this dataset, mental health treatments and benefits are defined separately from medical/surgical treatments and benefits. In turn, they are often handled separately and perceived as different issues. This then has a territorialising effect on how people view mental health in relation to medicine. This distinction between mental health treatment and medical treatment may contribute to the stigma associated with mental illness, which often dissuades people from seeking treatment.

Another example is the number of detailed definitions provided in the final rules and regulations for the MHPAEA. Before that document was published, the language used to define terms like "mental health benefits," "substance use disorder benefits," "financial requirements," and "treatment limits" were vague and enabled insurance companies to continue covering mental health and physical health using different parameters. With the original legislation, insurers could claim that their specific scenario was not mentioned and therefore still complied with the law. The final rules and regulations aim to close loopholes by addressing questions from stakeholders directly and describing how definitions applied to different contexts. The goal is to have more people receiving coverage for mental health treatment and, in turn, more people seeking and receiving that treatment. In other words, these detailed definitions intend to produce an aggregative flow that territorialises mental health coverage across providers, which would ostensibly lead to better material outcomes for those with mental health conditions.

Restricting/limiting, mandating, and permitting have similar effects because those actions within the legislation also determine what is allowed to exist or occur within the mental health system. After the ruling *Miller v. Alabama*, juvenile offenders could no longer be sentenced to life in prison without the possibility of parole in part because of the immense negative effects on their mental health. When juveniles commit serious crimes, they are often treated like adults, both within the judicial system and in the court of public opinion, so this ruling diverts attention away from their actions and directs attention to their status as children/minors. Prior to the

ruling, 28 states allowed juveniles to be sentenced to life without the possibility of parole. As of 2017, 14 states have changed their laws to comply with the federal ruling. Furthermore, in 2016, the Supreme Court ruled in *Montgomery v. Louisiana* that *Miller v. Alabama* must also be applied retroactively, meaning that individuals who had previously been sentenced to life without parole as a juvenile must now be considered for parole (Teigen, 2017). One prominent example (and one of the cases that was the impetus behind the ruling in the first place) is Kuntrell Jackson, who was sentenced to life without parole in 1999 when he was just 14-years-old. In 2017, as a result of the *Miller v. Alabama* and *Montgomery v. Louisiana* rulings, Jackson received new sentencing in 2013 and was subsequently released on parole in 2017 (ACLU Missouri, 2017; Equal Justice Initiative, 2013). He has since become a motivational speaker and prison reform advocate (Jackson, 2020). Although there aren't any available statistics on the number of individuals who have been re-sentenced and then subsequently released from prison as a result of these rulings, it's not a stretch to say that there are probably other juvenile offenders who have similar experiences, or who will have them in the future. Therefore, its material effects may include fewer juvenile offenders in jail for long periods of time, which could then lead to better outcomes for their mental health. The HIPAA Privacy rules, on the other hand, *permits* healthcare professionals to share mental health information with family members if the individual is a danger to themselves or others. This document functions in a similar way to the MHPAEA final rules and regulations: it clarifies a piece of legislation that had been previously ambiguous, and it solves a problem that many family members had faced in the past. When it comes to privacy, medical professionals often follow a strict interpretation of the ruling that doesn't allow for the sharing of any medical information to anyone besides the patient under any circumstances. This document allows for specific exceptions so that family members of individuals with serious mental illness can be actively involved in their care.

While definitions dictate perceptions and can direct attention—and even action—in particular ways, a provision in a piece of legislation that designates funding serves as a material representation of a government's values and priorities. In this case, the discursive is very much reality because the amount of money written in a legislative document is connected to an "actual"[5] sum of money that will be used to fund various programs and initiatives (Cloud, 1994).

[5] I put "actual" in quotation marks because the funding won't actually take the form of paper money, but it is still "real" in digital/electronic form.

Because we are led to believe that there is a finite amount of money that a government can spend, the issues and programs that are deemed the most useful, beneficial, or worthy get the most funding. Additionally, since budgets are typically updated annually or biannually, many programs and initiatives are constantly under threat because, depending on the current circumstances, they could face cuts, which is why funding is such an important issue highlighted within the NMHO advocacy materials.

When legislative bodies build a budget, they are essentially sending a macrorhetorical message signaling what and who they believe matters (McGee, 1982). And, as Leslie from NMHO Indiana expressed, a piece of legislation that creates a new program or organization isn't all that helpful without funding attached it because you need money to build or rent a space, advertise the program/organization, purchase materials, compensate staff, etc (Personal communication, October 23, 2018). This happened with the 2015 Indiana state legislation that established the Technical Assistance Center for crisis intervention teams. The original provision did not attach any funding to the center, so while the state endorsed (and required) the creation of this center, the lack of funding signaled that it wasn't necessarily a priority. Furthermore, because funding was not attached to the bill until 2017, the center is still a work in progress. When funding is attached to a program or an initiative from the beginning, it can lead to some positive material results. One successful example is the National Institutes of Health Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The BRAIN Initiative, which was launched in 2013 and has subsequently received funding in each of the biannual budget bills, is a collaboration between public and private research centers to better understand the functioning of the brain. The funding attached to the initiative provides grants to researchers who are working on projects that address an issue within the brain. One such project funded by the BRAIN Initiative was able to identify genes that may increase one's risk for developing schizophrenia (NINDS Press Team, 2017; Won, et al., 2016).

From both of these examples, we can see how the designation of funding translates into the material and also territorialises the two separate initiatives. In terms of the Technical Assistance Center, its actual founding and implementation has been delayed because the Law Enforcement Training Board and the Division of Mental Health and Addiction—who were in charge of its establishment—could not devote the proper resources needed to facilitate the center without funding from the state budget. On the other hand, because the BRAIN Initiative receives

millions of dollars in funding that then gets dispersed amongst teams of researchers, they are able to make discoveries that could potentially lead to better treatments for disorders like schizophrenia. Furthermore, the funding for these initiatives always comes with stipulations: in both cases identified above, they must follow certain protocols and can only use the funding for certain things. In this way, the language that designates funding, in addition to the actual funding itself, territorialises by producing order across all the projects that it enables.

Additionally, the BRAIN Initiative demonstrates how funding/money flows through the assemblage in a similar way to power. It starts at the "top" with the federal budget, then it goes to the NIH, a federal governmental agency, and then circulates "down" amongst research centers often affiliated with public or private educational institutions. We see a similar phenomenon occur with the Community Mental Health Services Block Grant mentioned earlier in the chapter. The funding emerges at the federal level and then is dispersed among the states who then circulate the money at the local level since community mental health centers are most often run by a county or a city/town government. Once again, the legislation that designates the funding comes with stipulations about how it can be used, and it also requires that all centers provide particular types of services and serve targeted populations. Therefore, the funding not only enables the centers to exist, but it also standardizes treatment and care across the country, even though the centers are technically "locally run" to meet the specific needs of the regional population. In other words, the funding comes with certain strings attached and those strings produce an aggregative flow that territorializes community treatment and the research performed at educational institutions.

Several other action codes identified in the dataset facilitate a literal "bringing together" of bodies in order to create resources and address issues. Those codes include "establishing," which was assigned whenever a provision establishes a new program, organization, or group, and "coordinating/integrating/collaborating," which was assigned whenever legislation facilitated collaborative initiatives among agencies or called for integrating medical/mental health services. In both instances, the legislation constructs situations that arrange spaces and bodies in particular ways—and also determines which bodies can participate and which can't. For example, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) created by the 21st Century Cures Act, includes representatives from various governmental agencies as well as experts from outside of the government. The 21st Century Cures Act lays out organizing

principles for the group (i.e. their purpose, the tasks they are meant to accomplish, how often they are required to meet, etc.) as well as who is invited to provide their opinion. Therefore, that provision in the legislation is territorialising because it standardizes the committee and dictates their organization. In a similar fashion, the 21st Century Cures Act also aims to integrate mental health into primary care. While integrated care could simply involve primary care physicians disseminating mental health information to their patients or adding a mental health screening to regular visits, it could also mean actually housing mental health services in primary care facilities so that that primary care physicians and mental health professionals could provide collaborative care. In this case, there is less structure than with the ISMICC, and primary care physicians/facilities seem to get a choice in how they integrate mental health care into their practice. Therefore, while the legislation does territorialise in its attempts to move towards integration, individual facilities are also able to do what makes the most sense for them in their particular context, so they are, in a way, deterritorialising because they could potentially create more innovative ways to provide this type of care.

The final two action codes, "evaluating/assessing" and "publishing/circulating," often go hand-in-hand and are connected to other codes such as "establishing." As stated in the previous chapter, provisions in legislation that establish a program often include an evaluative component to ensure that the program is meeting goals and addressing issues. Then, it is also expected that the findings of a study are circulated and made available to the public to maintain transparency. However, those codes did not always go together, and sometimes a provision would order an assessment to see if a future initiative might be necessary. For example, in 2014, the State Department of Health, the Indiana Department of Veterans' Affairs, and the Division of Mental Health Addiction were tasked with conducting a study on how to best treat veterans with traumatic brain injuries or posttraumatic stress disorder. This evaluation would determine if there was a need for a new program and, if so, what that program would look like. If the assessment in fact led to the creation of a new program, then it would have produced a singular flow that deterritorialised the assemblage because it would have been expanded. However, at the same time, the legislation would have territorialised the program itself by imposing rules and regulations, determining eligibility, etc.

5.5.3 Interferences from Other Components Can Deterritorialise Legislation and Thwart Aggregative Flows

In theory, the regulations established in a piece of legislation are legally binding and therefore must be enforced and result in some form of material action. However, other components will sometimes attempt to circumvent those regulations, and then no material change actually occurs. For example, "publishing/circulating" was most prevalent in the federal parity acts because one of their main purposes was to require insurance companies to make their plan information and reasons for claim denials more readily available to patients. This is meant to help patients make more informed decisions about their healthcare, but the reality is that most people are constrained by their employers or by the cost of the plan when they are choosing their health insurance. Alternatively, when actually given a choice, whether through an employer or health insurance marketplace, they may not understand how to compare and evaluate health insurance plans to determine which one is the "best" (Hoffman, 2019; Owens, 2020). Additionally, when someone is experiencing a serious health issue, such as a mental health crisis, that person is not able to really "shop around" for a provider. Therefore, with these types of provisions there is an attempt to territorialise insurance companies' policies by requiring them to provide this information with the goal of then enabling individuals to deterritorialise the system by choosing the most affordable plans with the best policies, which would then ostensibly drive down prices. However, this is a case where the legislation was not successful and has not led to any sort of significant material change in health insurance practices or accessibility of treatment.

Furthermore, according to Dangor (2019), the MHPAEA is also failing at its main goal: equal coverage between mental and physical health. Despite the detailed definitions and criteria provided in the final rules and regulations, insurers have still been able to evade parity mandates by redefining the term "medical necessity" and thereby only covering treatment up to the point where a patient is stabilized. Additionally, they often require patients to "try and fail" less expensive treatments before allowing them to use a more expensive treatment that may work better for them. Pelech & Hayford (2019) also found that private insurers pay less for mental health care—but more for physical health care—than Medicaid does, and the Health Care Cost Institute (2018) reported a faster increase in out-of-pocket spending on inpatient mental health care than on any other inpatient services. Finally, according to the National Institute of Mental Health (2019), less than half of all adults with any kind of mental illness receive treatment.

Therefore, once again, there is an attempt to produce an aggregative flow that territorialises health insurance, but the insurance companies in response produced singular flows that deterritorialised and resulted in new lines of flight that thwart the regulations. This is why mental health reform and parity is one of the primary topics discussed across the NMHO's documents/media: legislation and other components in this assemblage are constantly shifting and reacting to each other and creating new problems that the NMHO must then respond to.

5.5.4 Conclusion 4: The Interactions Amongst Symbolic/Expressive Components Provoke Incorporeal Transformations in the Material

As this section demonstrates, the elements within an assemblage are a combination of the physical/material and the expressive/symbolic. The interactions amongst the expressive/symbolic elements often provoke incorporeal transformations that affect how bodies, actions, and things exist in the world (Deleuze & Guattari, 1987). In the realm of advocacy and legislation, the language used in the NMHO's advocacy materials and in the legislative documents generated actions that led to new connections amongst lawmakers, health insurers, mental health professionals, and individuals with mental health conditions. However, the language used in the assemblage does not always guarantee action or physical change, particularly when another component within the assemblage attempts to evade the regulations set forth in a piece of legislation.

5.6 Conclusion

In this chapter, I have offered four major conclusions based on the findings detailed in Chapter 4:

- Mental health legislation and advocacy function more like a rhizomatic, multi-level assemblage than a pyramid-like hierarchy.
- Legislation primarily territorialises within the assemblage, meaning that it attempts to stabilize and standardize both the whole and the components within the assemblage.
- NMHO advocacy materials produce a combination of singular and aggregative flows that primarily deterritorialise the assemblage. Individual documents produce singular flows that cause their readers to think differently about an issue and then act in a particular way,

while sets of documents that are part of a coordinated strategy produce aggregative flows that shift societal values and drive institutional change.

- Interactions amongst symbolic/expressive components in the assemblage (i.e. the language used in the mental health legislation and advocacy materials) provoke incorporeal transformations in the material through actions that affect healthcare outcomes in the United States.

As this chapter demonstrates, the communication and documents/media circulated amongst the NMHO and legislative bodies at the federal, state, and local levels create interactions that produce lines of flight or flows that either stabilize/standardize (territorialise) or disrupt/expand (deterritorialise). While certain components, such as federal legislation or NMHO National materials, often have the most power and are the most likely to produce aggregative flows that affect documents/media at all levels, there are moments where less powerful stakeholders/components are able to exert influence and deterritorialise by calling attention to a particular issue or shifting priorities within the organization. Or, a major piece of legislation, like the MHPAEA, may fail to produce its intended effects due to other components in the assemblage creating new lines of flight that enable them to subvert those in power. Therefore, although federal, state, and local may on the surface seem like a hierarchy, it is much more accurate to theorize these levels of the NMHO and legislation as an assemblage because the relationships among components are fluid and constantly shifting based on social and historical processes. In Chapter 6, I first offer a more comprehensive discussion of the four conclusions presented in this chapter and how they work together to support my thesis. Then, I consider the implications of these conclusions for mental health advocacy organizations, legislators, and the fields of RHM and Rhetoric and Composition, and I suggest future directions for research.

CHAPTER 6: CONCLUSION

6.1 Introduction

The mental health legislative-advocacy assemblage examined in this project continues to evolve and grow as new exigencies present themselves and new components emerge and interact with existing components. For instance, right now, the mental health assemblage is greatly impacted by the COVID-19 pandemic and the Black Lives Matters protests against systemic racism following the murders of George Floyd, Breonna Taylor, and Ahmaud Arbery at the hands of police and white supremacists. The social upheaval as a result of the pandemic and the protests are in many ways linked to mental health because of the toll that they take on individuals' emotional wellbeing—especially those from marginalized populations, like Black Americans, who have been disproportionately affected by COVID-19 and who have been subjected to acts of racism their entire lives. Additionally, the healthcare system in general—particularly the Affordable Care Act, which guarantees that most insurance plans cover mental health—continues to face challenges from the Trump Administration. A lack of support from the federal level puts significant strain on state and local governments who must then deterritorailise the assemblage by developing their own solutions to the mental health issues that their communities face. In fact, Assemblage Theory is uniquely positioned to describe these kinds of evolving and unpredictable shifts in the United States mental health system. It provides a theory and terminology for the circulation of communication and how discursive systems intertwine with the material. My project in particular provides a framework that can be used to describe the larger movements that occur within an assemblage (i.e. affective flows that territorialise across the assemblage or deterritorialise in a way that creates a significant shift) as well as individual interactions (i.e. singular flows that deterritorialise one component of the assemblage) that have smaller effects but still alter the assemblage in some way. Combined with Rhetorical Ecologies and other rhetorical theories, it demonstrates the potential of discourse, texts, and media to produce reverberating affects across time and space and on physical bodies.

By using Assemblage theory, Rhetorical Ecologies, and several other rhetorical theories, the goal of this dissertation was to answer the following research questions:

- How do the different levels of mental health legislation and the different levels of a mental health advocacy organization interact and influence each other?
- How does federal, state, and local legislation impact the advocacy materials produced by mental health advocacy organizations?
- How do advocacy materials produced by mental health advocacy organizations attempt to impact federal, state, and local legislation?
- How do advocacy materials and legislation impact the United States mental health system at the federal, state, and local levels?

To answer these questions, I conducted interviews with NMHO staff members at all three levels of the organization and performed a qualitative coding analysis of mental health legislation and NMHO advocacy materials published between 2010 and 2019. Ultimately, the conclusions generated from my results support my thesis. My thesis is that the federal/national, state, and local levels of legislation and the NMHO interacted more like a rhizomatic assemblage rather than a pyramid-like hierarchy. Legislation, particularly from the federal level, did act as a territorialising force, and, more often than other documents in the dataset, it produced broad, reverberating affects across the assemblage. Nonetheless, NMHO advocacy materials from all three levels also deterritorialised and subverted the hierarchy through a combination of singular flows that persuaded readers to think and act in particular ways and aggregative flows that aim to shift societal values and drive institutional change. My study also found that this ebb and flow of territorialisation and deterritorialisation generated actions that led to material changes in the mental health system, such as better research and a greater variety of treatment options. However, that material change was not guaranteed, as some legislative initiatives—like mental health parity—failed to achieve their desired objectives because of noncompliance and interference from other components such as health insurance companies.

These conclusions suggest several things about the NMHO, legislation, and their rhetorical relationships. First, the structure of the NMHO and its tension between centralization and decentralization affords the organization some unique rhetorical opportunities. Since NMHO National largely handles the organization's advocacy strategy, they are able to present a coherent narrative that heightens their credibility and legitimacy to external stakeholders, like legislators. Then, they can utilize their grassroots structure—the members and supporters "on the ground"—to further increase their reach and demonstrate how these national issues matter at the state,

local, and individual levels. Additionally, because of their multi-leveled assemblage structure, they are able to persuade and communicate with lawmakers at all three levels of government. This is important because, unlike the NMHO, legislative bodies across the United States are disjointed and do not typically communicate with each other as they make decisions to enact laws. So, while NMHO National staff will sometimes talk with state or local legislators, they typically leave that task to the NMHO state and local affiliates who are these legislators' constituents and therefore have more leverage.

Second, my findings demonstrate why legislation is such a priority for the NMHO and other mental health advocacy organizations: the language used in legislative documents has systemic material consequences that can potentially alter mental health outcomes throughout the United States. This conclusion may seem obvious, but my dissertation uses Assemblage Theory to determine the rhetorical mechanisms that make legislation such a territorialising force. I found that the level, or rhetorical position, of the legislation matters—since federal legislation produces more aggregative flows that affect the other components in the assemblage, including state and local legislation. However, because legislation—no matter the level—is a part of a powerful government institution, its ability to influence and affect the mental health system is much greater than other types of documents. When a piece of legislation establishes a program and then defines its parameters in a particular way, the individuals who meet that criteria will get to benefit from the program, while those who don't will get excluded. Some bodies will get to gather and participate, while others will not. This is just one example of a type incorporeal transformation that can occur as a result of legislative language (Deleuze & Guattari, 1987).

Nonetheless, my findings also reveal that legislation can be shaped and influenced by stakeholders beyond government officials. Without interviewing the legislators who wrote and passed the laws featured in this study, it is difficult to measure the direct impact that NMHO advocacy initiatives have on legislative documents, because they aren't the only organization advocating for mental health issues. However, April from NMHO National offered one example—a 10% increase in funding for early psychosis programs—where legislators did in fact do exactly as the NMHO suggested. In this instance, NMHO National approached the issue from multiple angles by garnering public support and presenting both the systemic effects of early intervention programs and the effects on individuals. Additionally, as my results show, the NMHO perhaps campaigned the most intensely for the 2016 21st Century Cures Act and against

the 2017 American Health Care Act. In both cases, the NMHO got what they wanted: the 21st Century Cures Act was signed into law, and the American Health Care Act was struck down in the Senate. Therefore, we may speculate that the NMHO at least played a part in the fates of these legislative documents.

In the subsequent sections I discuss the implications of these conclusions for mental health advocacy organizations, the Rhetoric of Health and Medicine (RHM), Rhetoric and Composition, and Professional/Technical Writing pedagogy. I then close the chapter by discussing potential directions for future research.

6.2 Implications for Mental Health Advocacy Organizations

My findings and conclusions have several implications for mental health advocacy organizations. First, my research provides a framework for tracking the potential material impacts of advocacy initiatives and legislation. In Chapter 4, one of my major findings was that the NMHO used a significant portion of their advocacy materials to do two things: 1. Condemn or support legislation and 2. Educate their supporters and the general public about the contents of legislative documents. Staff members in charge of the organization's advocacy strategy could, therefore, use strategies inspired by Assemblage Theory to track the broader impact of the language used in legislative and policy documents down to the state and local levels. For example, in Chapter 4 I mention a provision from the Affordable Care Act (2010) called Investment in Tomorrow's Pediatric Health Care Workforce, which provides scholarships for medical or professional students specializing in pediatric mental health who agree to work in an underserved area after they graduate. NMHO National could potentially demonstrate how that provision has improved (or, on the other hand, hasn't improved) pediatric mental health outcomes in these underserved areas across the country. They could gather data about the number of pediatric mental health workers in these areas, as well as the stories of individuals who benefit from the services that those workers provide. Then, they could use their findings as evidence in communications with legislators and their supporters/general public. This strategy could generate collaborative efforts with state and local NMHO leaders, who could gather stories from their affiliate members and also communicate with state or local legislators about how that provision in the federal legislation has affected their own legislative initiatives. This would involve similar strategies that they already use—facts/evidence and personal stories—meaning

that they could use existing infrastructure to gather some of this information. Other nonprofits who perform similar work could also use this strategy in their own advocacy initiatives.

Furthermore, the NMHO could use Assemblage Theory principles to implement more ways to track the impact of their advocacy materials. In Chapter 4, I quote April and Ben from NMHO National who both described how they currently measure engagement with their initiatives—mainly through tracking the number of emails and calls that legislators receive about a particular issue. However, beyond that, they both agreed that their impact on legislation is difficult to measure because "policy is a long game," and so many other stakeholders are involved in the legislative process (April, Personal communication, November 9, 2018). The NMHO may be able to use digital technologies to demonstrate how their members/supporters and legislators interact with their advocacy materials. For example, using web analytics software such as Google Analytics, NMHO staff could track not only how users engage with their materials, but also the pages they navigate to after interacting with a piece of media such as a blog post or email. Functions such as Navigation Summary, Users Flow, and User Explorer visualize how a user interacts with web content (Google Support, n.d.). The NMHO could use these features to identify the patterns of members who engage with components of their website meant for advocacy and potentially determine if those materials lead them to take action, such as tweeting/posting or emailing a representative. Then, in addition to inquiring about the number of emails and calls, they could send out a survey to legislators that asked what persuaded them to vote in a particular way on a piece of legislation. Was it the volume of calls/emails? Was it someone's personal experience or a report featuring ample statistics/numerical evidence of a problem? If the former, they may be able to use Google Analytics (although phone calls, obviously, cannot be tracked in this way) to show how much of that volume was due to their materials that were written to influence legislators. If the latter, they could potentially trace that personal story or statistic back to a piece or a set of documents/media that they created. Either way, they would be demonstrating how their advocacy either territorialised or deterritorialised legislative initiatives (even though they probably wouldn't use that terminology). This would all, of course, be additional labor for a nonprofit staff that is already stretched thin, and obtaining meaningful results would also depend on the number of lawmakers who would actually respond to these questions. Some additional funding and infrastructure would most likely be required to make this type of research sustainable within the organization.

6.3 Implications for the Rhetoric of Health and Medicine and Rhetoric & Composition

My dissertation research also has several implications for the emerging field of Rhetoric of Health and Medicine (RHM) and more broadly the more established field of Rhetoric and Composition. In Chapter 2, I provided an overview of scholarship in RHM, and I found that much of the research has historically focused on the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) as a meta-genre that generates other forms of writing and communication in the field of mental health. My study demonstrates how legislation—particularly at the federal level—also acts as a meta-genre since it often generates new legislation at the state and local levels and is the exigence behind much of the advocacy materials produced by the NMHO. Additionally, in Chapter 4, I described how legislation generates particular actions that lead to material changes in the mental health system. Three of those actions—"establishing programs," "evaluating/assessing," and "publishing/circulating"—generate new forms of documentation and communication, such as web pages, reports, and forms. RHM researchers could build on these findings and produce more scholarship that studies legislation's impact on health and medicine. That research might focus not only on how legislation leads to new forms of writing and communication in health and medicine, but also on how legislation interacts with existing documentation to affect outcomes related to various healthcare and medical issues. My study focused specifically on mental health legislation, but as I was compiling the documents in my dataset, I encountered legislation related to biomedical research, pharmacology, and treatment/services for other types of health conditions, such as diabetes, heart disease, and cancer. RHM researchers might use similar frameworks or methodologies to study legislation's effects on other healthcare and medical-related topics.

More generally, my dissertation provides a methodology for engaging in institutional and systems research in RHM, as well as Rhetoric and Composition as a field. As I pointed out in Chapter 2, several prominent researchers in RHM have called for more scholarship that engages with broader discursive systems across health and medicine (Jensen, 2015; Keranen, 2014; Segal, 2009). However, RHM scholarship has largely not yet addressed how discursive systems within and among institutions and organizations affects medicine and healthcare. My dissertation draws parallels between Assemblage Theory and rhetorical theories such as Edbauer's (2005) Rhetorical Ecologies and Burke's (1966, 1969) identification and language as symbolic action and provides a method and terminology for researching how various discourses interact and

produce affects across institutions and organizations. I claim that Assemblage Theory is an ideal framework for this type of research because it focuses on both the "whole" and the "interactions among parts" (DeLanda, 2006; Deleuze & Guattari, 1987). Using Assemblage Theory, researchers in RHM can theorize and map how discourse that circulates within a system affects both the system as a whole and the individual components within it. It enables researchers to examine the relationships among micro, meso, and macro levels of communication—all of which, according to New Institutional Theory, contribute to the emergence of institutions and organizations and foster instances of institutional change (Baba et al, 2012; Brown et al., 2012; Cloutier & Langley, 2013). Moreover, Assemblage Theory is concerned with both the expressive/symbolic and the material/physical. Since the late 1990s, Rhetoric and Composition scholarship has becoming increasingly interested in concepts like embodiment and affect and how space, movement, and bodies are rhetorical (Adams, 2007; Bratta, 2015; Mendelson, 1998). Even more recently, scholarship has focused on inanimate objects or "things" as actors with rhetorical agency (Barnett & Boyle, 2016). Because Assemblage Theory does not claim to privilege human agents over nonhuman actors, it can be used to study not only the interactions among the discursive elements within a medical or healthcare institution or organization, but also the physical elements, such as pharmaceutical drugs, medical instruments, or surgical technology.

Furthermore, as I demonstrated in Chapter 3, much of the Rhetoric and Composition research that uses Assemblage Theory is more theoretical rather than empirical. I speculate that this is because something was inherently "lost in translation" from the French to English versions of Deleuze & Guattari's work, and, therefore, other theoretical scholars who have since taken up the theory have interpreted it and its core concepts in a number of ways. My framework is, in fact, yet another interpretation, but I believe the parallels that I identify among Assemblage Theory, Rhetorical Ecologies, Institutional Rhetorics, and Materialist Rhetorics demonstrate its compatibility with current thinking in the field. Researchers have moved beyond static texts and instead are concerned with how discourse circulates and interacts both with other discourses and physical bodies and objects. Assemblage Theory provides a framework for explaining what occurs a result of those interactions.

Thus, my dissertation offers an interpretation of Assemblage Theory grounded in rhetorical theory that I believe can be adapted to other institutional and organization contexts

within RHM and Rhetoric and Composition as a whole. For example, while explaining Assemblage Theory in Chapter 3, I used the university as one example of an assemblage to demonstrate the theory's key terminology, and Rhetoric and Composition scholars often research writing practices in postsecondary environments. Therefore, these scholars may be able to use similar methodologies as this dissertation project to study writing practices across university contexts. In fact, this framework could potentially be applied to a variety of other institutional or organizational contexts, including businesses/corporations, government agencies, and religious organizations.

6.4 Implications for Pedagogy

My research may also have pedagogical implications, particularly for technical and professional communication and healthcare writing, where much of the curricula focuses on genres circulated within and across institutional/organizational settings. These courses require students to analyze, write, and design documents/media often encountered in the workplace, such as reports, white papers, media kits, patient education materials, and patient charts. Instructors will most likely spend ample time discussing these genres in relation to audience/stakeholder expectations and surrounding context/environment (including technology and institutional/organizational expectations/cultures). However, they may not delve into how these documents/media interact and thereby affect each other and the organizations/institutions in which they are produced and circulated. A lesson on professional genres as components of a larger assemblage would help students understand these documents/media that they produce as a part of larger organizational/institutional systems, rather than static artifacts that seemingly disappear once they are completed, filed, and sent off to their intended audiences.

For example, if students are practicing patient charting in a healthcare writing class, they could write a short report/analysis on the other documents/media that the patient chart might interact with and the ways in which their patient chart may produce affects across the healthcare system in which they work. They could talk about how their notes on a patient's charts build on previous notes made either by themselves or other healthcare professionals. They could talk about the guidelines from insurance companies that require them to use particular codes/terminology to ensure that the patient's treatment is covered. They could even talk about the medical articles/textbooks that they had to read to acquire the knowledge to evaluate and

diagnose a patient. Then, in terms of the affects their patient chart creates, they might discuss how their evaluation, diagnosis, and the language/terminology that they use will affect the treatment that a patient receives. They could also speculate about the potential for their charts to be used for clinical studies and other types of health/medical research. This type of assignment, grounded in principles from Assemblage Theory, enables students to imagine how their writing matters beyond the immediate, static rhetorical situation.

6.5 Directions for Future Research

My research suggests that Rhetorical Ecologies and Assemblage Theory may be productive frameworks for studying communication within and amongst organizations and institutions. Therefore, researchers may be interested in applying these frameworks to other organizational/institutional contexts. For example, NMHO is a grassroots nonprofit with a national umbrella organization—a common structure for nonprofits in the United States, but not the only type. Therefore, this same framework could be applied to a smaller nonprofit that only serves a particular local or regional population—or to a global nonprofit that operates internationally.

Although legislation is an area of interest for this dissertation, my research focuses on the NMHO's perspective. As stated in Chapter 3, without the perspectives of the legislators who communicate with NMHO staff members, I cannot unequivocally conclude that the NMHO's advocacy initiatives were a deciding factor in passing particular pieces of legislation. Thus, future research may include interviews with legislators in addition to advocates. Furthermore, interviewing a greater number of staff members—and potentially including the perspectives of individuals who provided testimony or shared their story using other forms of media—would present a more complete picture of how advocacy and legislation not only influence each other but also impact the lived experiences of individuals who live with a mental health condition.

Additionally, one of my limitations that I identified in Chapter 3 is that I only focus on one organization. While the NMHO is a significant player in mental health advocacy (as evidenced by the contributions from April cited in Chapter 4), they aren't the only organization that communicates with legislators and performs mental health advocacy work. Therefore, one line of future research may attempt to replicate this study with a different organization that has a similar mission. Or, alternatively, other stakeholders involved in mental health advocacy could

be incorporated into the assemblage presented in this study. For example, several of the advocacy materials in this study's dataset—particularly several letters and reports—are co-authored or signed by organizations that partner or collaborate with the NMHO. It would be interesting to look at these organizations' materials in tandem with the NMHO's materials to examine how they may affect each other as they circulate throughout the public and through legislative bodies. Key staff members at these organizations could also be interviewed and asked about their relationship with the NMHO and the ways in which they work together (or possibly against each other) to enact institutional change.

As mentioned previously, Assemblage Theory is not only concerned with the realm of the expressive/symbolic but also the physical, which includes various forms of technology. Throughout this dissertation, I say that the advocacy materials and legislation circulate and interact throughout the legislative-advocacy assemblage. However, I focus specifically on how they interact symbolically through their content and ideas, not how they may "physically" circulate. I put "physically" in scare quotes because a majority of the media that I include in this dataset would be circulated using digital technologies like social media and email, which are often disassociated from the material. Yet, these technologies are often referred to as digital "spaces" "environments," or "platforms," all words that connote material associations. Furthermore, all digital technologies have physical components, such as servers, satellites, fiber optics, laptops, and smartphones that enable them to function. Therefore, another direction in which to expand this research is by taking into account how digital technologies facilitate the circulation and interactions amongst the discursive components within this legislative-advocacy assemblage. Moreover, because advocacy also occurs in "actual" physical spaces, such as through meet and greets with legislators or in legislative forums, it would also be productive to take into account how the "bringing together" of bodies into a particular space affect mental health legislation and advocacy.

Finally, because of time constraints, I only collected documents that were published up until June 2019. The assemblage parameters could be expanded to include more recent legislation and communications, including media that addresses current issues such as the COVID-19 pandemic and the Black Lives Matter movement (as mentioned previously). Since I am a member of the NMHO and follow their pages on several social media platforms, I know that they have responded to these events through blog posts, webinars, and other types of media.

A follow-up study could begin by starting off where the current study ended and examining how these major events impact the NMHO's advocacy initiatives and mental health legislation. Furthermore, in Chapters 4 and 5, I point to NMHO encouraging their members and supporters to share posts using particular hashtags. My study did not attempt to analyze the circulation of those hashtags and the lines of flight that they may create, so social media could be a more significant focus in a future study.

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APPENDIX A: INTERVIEW PARTICIPANT RECRUITMENT EMAIL

Dear [insert name here],

My name is Lindsey Macdonald, and I am a PhD candidate in the Rhetoric and Composition program at Purdue University. I am inviting you to take part in a study that uses the National Mental Health Organization (NMHO) as a research site for a case study. This study examines how the professional writing that occurs within healthcare advocacy organizations—in addition to healthcare legislation at the federal and state levels—represents a collection of documentation that has a direct impact on initiatives that improve access and affordability of healthcare at the local level, and, conversely, how those local initiatives often provoke changes at the state and federal level.

You have been asked to participate in this study for one or more of the following reasons: 1) You are a staff member at either NMHO National, NMHO Indiana, or NMHO Local; 2) Your position within the organization requires you to work with professional documentation that deals with public policy, advocacy, or community outreach; 3) Your position requires you to communicate or interact with the different levels of NMHO; 4) Your position requires you to communicate or interact with federal and/or state lawmakers.

If you choose to participate in this study, you will be interviewed either in-person, over the phone, through video chat, or through email (You may choose the medium of communication). You will be asked a series of questions about your role at NMHO, the types of writing and documents that you work with and produce, how those documents impact the community, and how legislation affects the documents you produce and how NMHO serves the community. Attached to this email, you will find a copy of the questions that you will be asked during the interview as well as a copy of an informed consent form. If you are willing and able to participate, please carefully read both documents, respond to this email with any questions or concerns that you have about the study, and indicate your preferred form of communication, and dates/times you are available to complete the interview.

If you are completing your interview in-person, at the beginning of your interview, we will review the informed consent form, and we will both sign it. If you are completing your interview over the phone, through video chat, or asynchronously (over email), I will ask you to send me a second email where you indicate your understanding of the study and your role as a participant and send me either a form with a digital signature or one that has been signed and scanned.

I greatly appreciate your time and look forward to speaking with you soon.

Best,

Lindsey Macdonald
PhD Candidate in Rhetoric and Composition, Purdue University

APPENDIX B: INTERVIEW PARTICIPANT CONSENT FORM

Key Information

Please take time to review this information carefully. This is a research study. Your participation in this study is voluntary, which means that you may choose not to participate at any time without penalty or loss of benefits to which you are otherwise entitled. You may ask questions to the researchers about the study whenever you would like. If you decide to take part in the study, you will be asked to sign, or agree to this form; be sure you understand what you will do and any possible risks or benefits.

This study examines how federal and state legislation impacts the types of professional writing and documentation produced by healthcare advocacy organizations, how that documentation impacts healthcare initiatives at the local level, and, in turn, how local initiatives provoke change at the state and federal levels. The entire research project will take place over the course of approximately twelve months.

What is the purpose of this study?

The purpose of this research study is to show how health advocacy groups fit into the broader healthcare system in the United States by examining how the professional writing that occurs within healthcare advocacy organizations—in addition to healthcare legislation at the federal and state levels—represents a collection of documentation that has a direct impact on initiatives that improve access and affordability of healthcare at the local level and, conversely, how those local initiatives often provoke changes at the state and federal level. The primary questions that this study aims to answer include the following:

- How does federal and state legislation impact the types of professional writing and documentation produced by healthcare advocacy organizations?
- How does the documentation that gets produced (and, in turn, the federal and state legislation) impact healthcare initiatives at the local level?
- How do local initiatives provoke changes at the state and federal level?

To answer these questions, I am performing a case study that uses the National Mental Health Organization (NMHO) as a research site to show legislation and professional documentation

interact within the American healthcare system, and, in turn, affect advocacy organizations' local initiatives and, conversely, how the local affects issues at the state and national level. Through this case study, I examine how NMHO's professional documents contribute to the organizational goals and structure as well as the relationship between these professional documents and legislation.

You have been asked to participate in this study for one or more of the following reasons: 1) You are a staff member at either NMHO National, NMHO Indiana, or NMHO Local; 2) Your position within the organization requires you to work with professional documentation that deals with public policy, advocacy, or community outreach; 3) Your position requires you to communicate or interact with the different levels of NMHO; 4) Your position requires you to communicate or interact with federal and/or state lawmakers.

I plan to enroll a maximum of fifty-six participants, as this is the number of staff members from all three levels that I have identified who fit the criteria listed above.

What will I do if I choose to be in this study?

If you choose to participate in this study as interviewee, you will be interviewed either in-person, over the phone, through video chat, or through email (You may choose the medium of communication). You will be asked a series of questions about your role at NMHO, the types of writing and documents that you work with and produce, how those documents impact the community, and how legislation affects the documents you produce and how NMHO serves the community.

With your permission, these interviews will be recorded for recall purposes. You can request the researcher not record your interview, leave the interview at any time, and/or choose to not answer any question.

How long will I be in this study?

You will only be asked to complete one interview, which will last approximately forty-five minutes to one hour.

What are the possible risks or discomforts?

The risk level for this study is minimal, as it is no greater than what you would encounter in daily life. Your identity will not be disclosed, and I will be asking you to assign yourself a pseudonym. Additionally, I will not be asking you any questions that require you to reveal sensitive, personal information. However, there is still a small risk that you could be identified since the position that you hold within the organization is publicly available through NMHO's website. To combat this risk, I will also use a pseudonym for NMHO as an organization.

Are there any potential benefits?

There are no direct benefits to the participants in this study. Indirect benefits to participants in this study may include information that they can use to assess the community impact of NMHO's resources, and data that shows how they are impacted by federal and state legislation.

Possible benefits to society may include increased awareness about the effects of legislation on local issues relating to healthcare, as well as new methods to assess community impact and show the effect that broader legislative and political systems have on local communities.

Will information about me and my participation be kept confidential?

This project's research records may be reviewed by departments at Purdue University responsible for regulatory and research oversight.

I will use a pseudonym for the organization, and I will ask you as a participant to assign yourself a pseudonym. My purpose in using a pseudonym for NMHO is so that I can refer to participants' positions within the organization without their identities becoming compromised.

I will have a code key that includes a number for each participant, all participants' pseudonyms, their position title, and which level of the organization they work for (national, state, local). Each interviewees' audio file will be labeled with their assigned number in the key. I will be the only researcher who has access to this key and the audio files, and they will be stored digitally in a password protected folder.

What are my rights if I take part in this study?

Your participation in this study is voluntary. You may choose not to participate or, if you agree to participate, you can withdraw your participation at any time without penalty or loss of benefits to which you are otherwise entitled.

You may ask to not have your interview recorded.

If you wish to withdraw from the study—or wish to withdraw the data from your interview—you can email Lindsey Macdonald at macdonl@purdue.edu and ask that your information be removed from the code key and/or your interview audio file be destroyed.

Your decision to participate or not in this study will have no effect on your relationship with NMHO.

Who can I contact if I have questions about the study?

If you have questions, comments, or concerns about this research project, you can talk to one of the researchers. Please contact Richard Johnson-Sheehan at rjohnso@purdue.edu or Lindsey Macdonald at macdonl@purdue.edu.

If you have questions about your rights while taking part in the study or have concerns about the treatment of research participants, please call the Human Research Protection Program at (765) 494-5942, email (irb@purdue.edu) or write to:

Human Research Protection Program – Purdue University
Ernest C. Young Hall, Room 1032
155 S. Grant St.,
West Lafayette, IN 47907-2114

Documentation of Informed Consent

I have had the opportunity to read this consent form and have the research study explained. I have had the opportunity to ask questions about the research study, and my questions have been

answered. I am prepared to participate in the research study. I will be offered a copy of this consent form after I sign it.

_____	_____
Participant's Signature	Date
_____	
Participant's Name	
_____	_____
Researcher's Signature	Date

APPENDIX C: INTERVIEW QUESTIONS

1. Do you work for NMHO National, NMHO Indiana, or NMHO Local?
2. Describe your role at NMHO. What is the title of your position, and what do you do on a day-to-day basis?
3. What types of documents do you write or work with regularly? Describe how you use these documents and how they impact your role at NMHO.
4. Do you feel that the documents you work with have an impact on community initiatives? If so, how would you describe that impact?
5. [For staff members at NMHO Indiana or Local] How do you use materials produced by NMHO at the national or state level?
6. Has any of NMHO's (or any other local affiliate) impacted NMHO at the national or state level?
7. How would you describe the impact that state and/or federal policy and legislation have on NMHO's mission and goals?
8. How would you describe the impact that state and/or federal policy and legislation have on the types of writing/documents that NMHO produces?
9. How would you describe the impact that state and/or federal policy and legislation have on mental health issues in local communities?
10. What is your relationship to state and/or federal lawmakers? How often do you interact with them?
11. How does [NMHO National, NMHO Indiana, or NMHO Local] assess and measure community impact?
12. What is your perception of NMHO's impact on mental health?