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Analysis of Stigmatic Content in State Mental Health Legislative Proposals

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

by

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Abstract

ANALYSIS OF STIGMATIC CONTENT IN STATE MENTAL HEALTH LEGISLATIVE PROPOSALS

By David L. Conley, MSW, Ph.D. Candidate

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2020

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Despite the proven effectiveness of mental health interventions, services remain limited across the country. Social workers have repeatedly advocated for increased funding, but mental healthcare gaps persist. Disparities could be addressed through the policy process, but critical proposals often do not pass. One of the biggest barriers is the concept of stigma, which could extend into legislatures and influence mental health-related policy outcomes as a form of structural stigma. Factors that influence legislator voting behavior are found in the literature, but studies have not explicitly focused on structural stigma or mental health-specific policy outcomes. Thus, the present study aimed to explore state mental health legislative proposals with goals of exposing forms of structural stigma present in the language and potential effect of the bills as well as identifying and disseminating patterns in mental healthcare policy outcomes. To achieve this aim, quantitative content analysis was conducted on a stratified random sample of bills that were codified into frequencies and examined through multiple logistic regression analyses. The study found that bills were structurally stigmatic in language and potential effect. Male and Republican legislators were more likely to introduce structurally stigmatic mental health bills, while party majority status and structural stigma in the language of the bills predicted mental health bill passage. Mental health advocates can utilize this information to better target policymakers for structural stigma reduction efforts as well as to increase their effectiveness in influencing bill sponsorship or voting behavior.

Keywords: structural stigma, mental health, legislation, policy outcomes

Chapter 1: Introduction

Problem Statement

In their 2013-2020 Mental Health Action Plan, the World Health Organization (WHO) conceptualized mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (p. 6). Mental health treatments and services designed to assist in the realization of the WHO’s conceptualization are effective in improving outcomes for clients, yet many do not benefit, as access to—and receipt of—services remains limited across the country (Cohen Veterans Network [CVN] & National Council for Behavioral Health [NCBH], 2018). For example, 57% of adults with any mental illness (AMI; Substance Abuse and Mental Health Services Administration [SAMHSA], 2018) do not receive any form of mental health treatment.

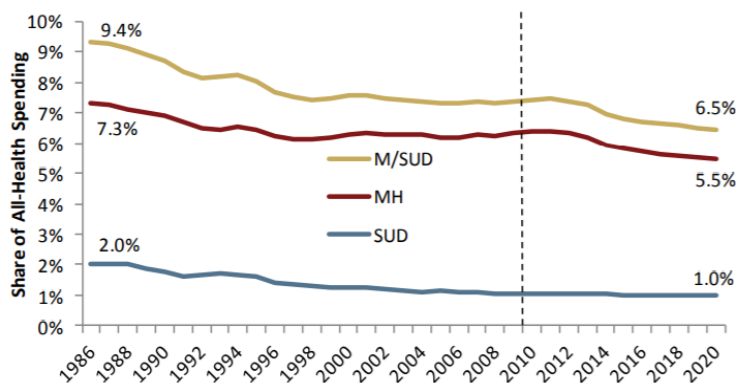
Existing gaps in mental healthcare access and services could be partially addressed through policy implementation at the legislative level (Freeman et al., 2005; Raghavan et al., 2008; & WHO et al., 2008). Mental health legislation provides a legal framework for addressing critical issues, including the availability and access of high-quality services (WHO, 2003), and legislators have the power to shape the United States’ mental health system through their legislative decisions (Purtle et al., 2017). However, efforts to increase access are dependent upon favorable legislative decisions, and demonstrating the effectiveness of human services with empirical evidence does not always ensure passage of a particular bill (Raghavan et al., 2008). Valuable health-related legislation often does not pass, denying vulnerable populations any health benefits contained in the language of the policy (Tung et al., 2012).

The lack of legislative attention and inequities in access and services may be related to the public’s perception of mental health. Many Americans prioritize physical health over mental

health, particularly in the areas of insurance coverage (Maust et al., 2015) and funding (Matschinger & Angermeyer, 2004; McSween, 2002; Smith et al., 2012). For example, in a nationally representative sample, adults were asked to prioritize mental and physical healthcare services to be covered by insurance (Maust et al., 2015). The authors found that public support for mental health care coverage was lower than nearly all physical health services and had not improved from earlier studies (i.e., Barry & McGinty, 2014; Hanson, 1998). Another nationally representative sample found that adults were willing to pay 40% less to prevent mental illnesses when compared to physical illnesses, despite the fact that they rated in-depth descriptions of mental illnesses as more burdensome to quality of life (Smith et al., 2012). The federal budget seems to reflect public sentiment, as the percentage of mental healthcare allocations have decreased overtime, and are projected to continue to decrease moving forward (Figure 1). For example, in 1986, 9.4% of all healthcare spending was allocated toward behavioral health (i.e., mental health or substance use disorder healthcare), but may decrease to 6.5% by the end of this year (Mark et al., 2014; SAMHSA, 2014).

Figure 1

Behavioral Healthcare Share of All-Health Spending, 1986-2020



Note. Source: SAMHSA Spending Estimates, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group (SAMHSA, 2014).

The above indicate a prioritization of physical health services and a devaluing of mental health services among the American public. As a result, individuals with mental health conditions are likely to face greater barriers to healthcare than those with physical health conditions (Henderson et al., 2013). One such critical barrier perpetuating America's prioritization of physical health, including the current gap in mental healthcare access and services, is the concept of stigma (CVN & NCBH, 2018; U.S. Department of Health and Human Services [HHS], 1999; WHO et al., 2008).

Effects of Stigma

Goffman (1963) notes that the word stigma stems from the Greeks and is described as a mark, scar, or brand. He defines stigma as “an attribute that is deeply discrediting” and reduces the stigmatized “from a whole and usual person to a tainted, discounted one” (p.3). Stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that is devalued (Crocker et al., 1998). Stigma can manifest at multiple levels, including the individual (Rüsch et al., 2009; Schomerus & Angermeyer, 2008), the community (e.g. public attitudes and behaviors) (Matschinger & Angermeyer, 2004; Smith et al., 2012), and the structure or institution (e.g., policy, funding) (Corrigan, Markowitz, & Watson, 2004; Corrigan & Watson, 2003; Corrigan, Watson, Warpinski, & Gracia, 2004). Stigma has an effect on the distribution of life chances (Link & Phelan, 2006) and is a fundamental cause of health inequities because it influences health outcomes and disrupts access to services (Hatzenbuehler, Phelan, & Link, 2013).

Mental illness stigma, in particular, is a pressing issue that is one of the biggest obstacles to future progress in the arena of mental health (HHS, 1999; WHO et al., 2008). Despite increased public knowledge and awareness regarding mental health, many Americans still hold stigmatizing attitudes that have not decreased over time (Parcesepe & Cabassa, 2013). For

example, results from the 2006 General Social Survey (GSS) stigma modules indicated that mental illness stigma levels remained high and did not decrease between decades (Pescosolido et al., 2010). Forms and consequences of mental illness stigma are discussed in greater detail in this chapter's literature review.

Stigmatic public attitudes can extend into legislatures and become a form of structural stigma, affecting policy outcomes on legislation related to mental health and mental illness (herein referred to as MHMI). For example, stigmatic public opinion is inversely correlated with public support for positive mental health legislation (Corrigan et al. 2004). Legislators who endorse stigma—through negative public opinion or their own negative past experiences—can block funding for services (Corrigan, Watson, et al., 2004), pass stigmatizing legislation, or engage in policy inaction, prioritizing their own agendas and ignoring the concerns of stigmatized groups (Link & Hatzenbuehler, 2016). In sum, the public's prioritization of physical health over mental health could be a result of stigma, which could extend into legislative structures and affect voting outcomes.

Review of the Literature

The core concepts of MHMI stigma and legislative influence (i.e., factors that influence bill outcomes) guide this dissertation and are integral to its research questions. While research is limited regarding their intersection, both have been studied separately at length. Thus, the purpose of this literature review is to describe both concepts in-depth as well as discuss relevant literature related to their underlying constructs.

MHMI Stigma

Link and Phelan (2001) assert that stigma occurs when five elements (i.e., labeling, stereotyping, separation, status loss, and discrimination) co-occur in a situation of power.

According to the authors, the stigmatization process occurs when (1) society distinguishes and labels individuals and their differences, (2) beliefs in dominant culture link these labeled individuals to undesirable characteristics or negative stereotypes, (3) labeled individuals are categorized to accomplish a degree of conceptual or literal separation (“keep us away from them”), (4) labeled individuals experience some form of status loss, and (5) labeled, stereotyped individuals experience discrimination leading to negative outcomes. As previously mentioned, stigma can occur at the individual, public, and structural levels. While the primary focus of the proposed study will be structural stigma, stigma at all levels affects mental health access and service utilization in different ways.

MHMI Self-stigma

Because of the existence of societal and structural stigmas, individuals in stigmatized groups may experience self-stigmatization or anticipated discrimination. Self-stigmatization occurs when members of a vulnerable population or stigmatized group begin to believe they are of lesser value and will be rejected by society, internalizing the stigmatic narratives of their social environments (Schomerus & Angermeyer, 2008). Specifically, 31% of Americans with MHMI conditions worry about being judged when sharing their mental health service utilization with others, and 21% have lied to avoid sharing (CVN, 2018). Self-stigma can negatively affect all aspects of an individual's life (Caltaux, 2003), potentially resulting in the ‘why try’ effect: the individual is less likely to pursue life goals, deciding that they have already failed due to having a mental illness (Corrigan, 2004; Corrigan & Wassel, 2008). Consequences associated with self-stigmatization include diminished self-esteem, low self-efficacy (Rüsch et al., 2009), increased anger or indifference (Corrigan & Watson, 2002), reduced readiness to seek professional help

(Clement et al., 2015; Corrigan et al., 2014; Schomerus & Angermeyer, 2008), and suicidality (Oexle et al., 2017).

Individuals not self-stigmatizing may still choose against starting professional treatment or accessing available services in order to prevent future discrimination (Rüsch et al., 2005) or labeling, even when there are no barriers to care (Corrigan, 2004). Minorities, youth, adult men, members of the military, and health professionals disproportionately choose against seeking help for fear of being stigmatized (Clement et al., 2015). For example, in Hoge et al.'s (2004) study, the majority of soldiers returning home did not seek mental healthcare, largely related to concerns about possible public discrimination. Those attempting to prevent discrimination may instead choose alternatives to professional care, such as members of the clergy (Wang, 2003), who may not be adequately trained to address a wide range of mental health conditions.

Public MHMI Stigma

Public stigma refers to “reactions of the general public towards a group based on stigma about that group” (Rüsch et al., 2005, p. 530). Corrigan and Watson (2002) outline the public stigma process in their social cognitive paradigm: (1) individuals with mental illness are perceived negatively and stereotyped into categories (e.g., dangerous, responsible for their illness), (2) the prejudiced public then endorses these stereotypes, and (3) a discriminatory behavioral reaction occurs against the stigmatized group.

There are many consequences associated with public stigma. In their systematic review, Parcesepe and Cabassa (2013) found 36 articles reporting outcomes from population-based studies of the public stigma of mental illness. Results indicated that public stigma led to social segregation and reduced self-efficacy (Corrigan & Shapiro, 2010; Parcesepe & Cabassa, 2013; Pescosolido et al., 2007) as well as forms of structural stigma, such as limited financial

autonomy, restricted opportunities, and forced treatments, including mandatory participation in services (Corrigan & Shapiro, 2010; Pescosolido et al., 2007).

Public stigma also affects the public policy process. Because legislator attitudes are influenced by public opinion (McSween, 2002) and form from group perceptions (Nelson & Kinder, 1996), it follows that if the public's opinion toward a certain group is stigmatized, legislator attitudes toward that group may also be stigmatized through stereotype endorsement from the public or their own personal prejudices. Thus, a stigmatized group may not be able to gain public policy support because of discrimination (Schneider & Ingram, 1993). As mentioned earlier, this idea is supported in the literature, as stigmatic public attitudes toward mental illness are negatively associated with supportive legislation (Barry & McGinty, 2014), funding (Corrigan, Watson, et al., 2004; Matschinger & Angermeyer, 2004; McSween, 2002), and access to care (WHO, 2003).

Factors Influencing Public MHMI Stigma. The literature suggests that stigmatic public attitudes regarding MHMI are influenced and/or sustained by certain factors discussed below.

Knowledge and Awareness. Increased public knowledge and awareness could positively influence social norms, and both have increased over time; however, as described above, public stigma has yet to decrease (Pescosolido et al., 2010; Schomerus et al., 2012). Past research posits that public stigma could persist because of the way well-intentioned public education campaigns are framed. MHMI conditions are often framed as brain diseases, which could have unintended consequences, such as increased public attitudes of 'difference' and 'the unlikelihood of recovery' (Pescosolido et al., 2010; Schomerus et al., 2012; Trujols, 2015).

Contact. In their meta-analysis on outcome studies related to challenging mental illness public stigma, Corrigan et al. (2012) found that personal contact between members of the public

and people with mental illness significantly improved the stigmatizing attitudes and behavioral intentions of the public toward people with mental illness. Further, contact has been associated with attitudes of decreased dangerousness (Whaley, 1997) and reduced desire for social distance (Boyd et al., 2010), as individuals with a diagnosis or individuals with a family member with a diagnosis were less likely to endorse MHMI stigma (Deluca & Yanos, 2016). Finally, Corrigan (2011) found that multiple positive contacts are more effective than single encounters. However, this isn't universally true, as contact sometimes makes stigma worse, depending on an individual's stage of recovery or their disorder's severity (National Academies of Sciences, Engineering, and Medicine [NASEM], 2016).

Perceived Dangerousness or Unpredictability. People with MHMI conditions are often associated with violence and unpredictability in the public (Martin et al., 2000, 2007; Phelan, Link et al., 2000). For example, 40% of Americans believed youth and teens with depression were likely to be violent (Pescosolido, 2013). As a result, members of the public (Corrigan et al., 2002; Link et al., 1999; Pescosolido et al., 1999), including healthcare professionals (Levey & Howells, 1994), often view people with MHMI as dangerous. However, people with MHMI are no more violent than the general population, and only about 4% of violent acts can be attributed to individuals with serious mental illness (SMI; HHS, 2017). Further, several studies have found that people with MHMI conditions are actually at higher risk of victimization than the general public (Choe et al., 2008; Desmarais et al., 2014; Khalifeh et al., 2015). Nevertheless, perceptions of dangerousness have not reduced over time, despite the increase of MHMI knowledge and awareness (Pescosolido et al., 2010; Phelan et al., 2000). One of the strongest influences on the public perception of dangerousness is the media, a relationship that is discussed further below.

Attributions of Cause or Blame. Another stigmatizing public stereotype about people with MHMI is that they are to blame for their own conditions and should be held personally responsible (Corrigan et al., 2000; Weiner et al., 1988). The literature notes that the public views people with psychiatric disorders as more to blame than those with physical health conditions (Corrigan et al., 2001; Weiner et al., 1988). Attributing MHMI conditions to neurobiological causes could reduce blame, but past research is conflicting. A neurobiological conceptualization of psychiatric illness can actually increase perceptions of difference (Phelan, 2005) and decrease perceptions of self-efficacy and ability to cope (Trujols, 2015).

Media Coverage. Traditionally, the public relies on both printed and broadcast media as their primary source of information regarding MHMI issues (Anderson, 2003; Borinstein, 1992; Hannigan, 1999; Reavley et al., 2011; Philo et al., 1994). In a recent systematic review on the impact of different forms of media on SMI stigma, Ross and colleagues found that the tone of news reports was associated with stigmatizing attitudes (Ross et al., 2019). For example, positive stories of recovery led to decreased prejudicial attitudes and increased belief in treatment effectiveness (McGinty et al., 2015), while negative portrayals were associated with negative public attitudes (Angermeyer & Matschinger, 1996; Edney, 2004; Wahl, 1992; Wahl, 1995) as well as negative impacts on social policies (Cutcliffe & Hannigan, 2001; Rose, 1998).

Individuals with MHMI conditions are often negatively portrayed in the media as violent, which enables associations of crime and dangerousness (Bowen, 2016; Bowen & Lovell, 2013; Corrigan et al., 2005; Diefenbach & West, 2007; Klin & Lemish, 2008; McGinty et al., 2016; Wahl et al., 2002). For instance, in a content analysis of U.S. news coverage of mental health conditions, Corrigan et al. (2005) found that 39% of the stories made the association between MHMI and dangerousness.

Lastly, emerging research is beginning to examine the relationship between social media and stigmatizing attitudes. As with other forms of media, social media can either perpetuate stereotypes of dangerousness (Budenz et al., 2018) and negative attitudes toward specific disorders (Budenz et al., 2020; Joseph et al., 2015), or be used to reduce stigmatizing attitudes (Miles, 2016) and provide social support (Budenz et al., 2020).

Structural MHMI Stigma

While the above forms of stigma are important in terms of the context of the concept of stigma overall, the main construct for the present study is structural stigma. Hatzenbuehler and Link (2014) broadly define structural stigma as societal conditions, norms, and policies that constrain the opportunities and resources of stigmatized individuals. Structural stigma occurs through prejudices of those in power who enact policies that discriminate against certain groups (Pincus, 1996, 1999). Phelan et al. (2008) identified a typology of three functions of structural stigma that perpetuate discrimination and its consequences for stigmatized groups: (1) keeping people “down” through domination or exploitation, (2) keeping people “in” through social norm enforcement and punishment for norm breakers, and (3) keeping people “away” through avoidance and separation. Structural stigma can create structural disadvantages for stigmatized groups that can accumulate and reproduce over time (Hatzenbuehler et al., 2013), ultimately resulting in discrimination and status loss (Link & Phelan, 2001).

Specifically referring to mental illness, Corrigan and O’Shaughnessy (2007) define structural stigma as the policies of institutions that intentionally or unintentionally create limitations for people with mental health conditions, such as access to resources and opportunities. If a disease or disorder becomes stigmatized, social policies can either protect individuals from societal prejudice, perpetuate discrimination against them, or ignore the stigmatization process entirely

(Herek et al., 2003; Link & Hatzenbuehler, 2016). The resulting disadvantages or consequences for people with MHMI conditions can manifest in numerous areas, which are discussed further below.

Consequences of Structural MHMI Stigma. Past research suggests that forms of structural stigma are associated with disadvantages for people with MHMI conditions, manifesting in systems such as criminal justice, healthcare, housing/employment, and public policy.

Criminal Justice. The criminal justice system is a form of structural stigma for people with MHMI conditions, as represented in the literature. For example, people with mental illness were found to be arrested at higher rates (Link et al., 1992) and faced a 50% increase in the odds of incarceration if arrested with a misdemeanor, compared to people without a mental illness (Hall et al., 2019). There are also a disproportionate number of people with MHMI conditions already in the system: 64% of jailed inmates reported mental health problems (James & Glaze, 2006), while 44% reported histories of mental disorders (Bronson & Berzofsky, 2017). Further, the majority of U.S. states have more individuals with MHMI conditions in jails or prisons than in psychiatric hospitals (Torrey et al., 2014). Finally, incarcerated individuals with MHMI conditions had longer sentences and were more likely to have multiple arrests on their record than those without (James & Glaze, 2006).

Healthcare. Structural stigma is evident in the U.S. healthcare system and manifests itself in the low quality of care and limited access to resources for people with MHMI conditions. MHMI treatments and services receive far less funding compared to physical healthcare (Mark et al., 2014; SAMHSA, 2014), despite their evidence of return on investments (National Association of State Mental Health Program Directors [NASMHPD], 2012). Further, MHMI insurance benefits are more limited than physical health services, even after the Mental Health Parity and Addiction

Equity Act of 2008 (MHPAEA) was passed (Xu et al., 2019; Zhu et al., 2017). Lastly, as mentioned earlier, individuals with MHMI conditions ultimately face greater barriers to healthcare than those with physical health conditions (Henderson et al., 2013).

Housing & Employment. People with MHMI conditions experience structural stigma in the housing system resulting in discrimination (e.g., Corrigan et al., 2006, Page, 1995; Tsai et al., 2011). Those with MHMI conditions are less likely to be able to lease an apartment (Page, 1995), more likely to be segregated (Metraux et al., 2007), or are not wanted at all as neighbors (Piat, 2000). The employment process can also be discriminatory, as those with MHMI conditions are typically underemployed (Link, 1982; Luciano & Meara, 2014; Wahl, 1999) or earn substantially less than the general population (Levinson et al., 2010). For example, in 2010, 62% of people without mental illness were employed full-time, while only 38% of people with SMI held full-time positions (Luciano et al., 2014). This discrepancy could be due to employer attitudes: (1) half of employers would ‘rarely’ employ an individual with a psychiatric disorder, (2) a quarter would ‘fire’ someone who hadn’t disclosed a mental illness (Manning & White, 1995), and (3) many individuals with MHMI conditions reported being turned down for a job or having the job offer rescinded once their psychiatric histories became known (Wahl, 1999). Green et al. (2003) suggest that the above may occur as a result of employer assumptions regarding the dangerousness or unpredictability of people with MHMI conditions.

Public Policy. Other critical examples of structural stigma are policies that constrain the opportunities and resources of people with MHMI conditions. Albeit limited, past research has examined structurally stigmatic policies in state legislatures. Using keywords representing mental illness (mentally ill, mentally incompetent), two studies searched legislation across all 50 states and found restrictions for people with MHMI conditions in the areas of jury duty, voting,

divorce, parenting, and holding elective office (Burton, 1990; Hemmens et al., 2002). Specifically, Hemmens et al. (2002) found that by 1999, 88% of states restricted rights related to participating on a jury; 74% restricted rights related to voting; 54% restricted rights related to divorce and parenting; and, 48% restricted rights related to holding public office. Similarly, in a 2002 review of 1,000 mental health-related legislative proposals from across the country, Corrigan et al. (2005) found that an average of roughly 6% were structurally stigmatic in their intent: 11% of bills restricted protections from discrimination, 4% restricted privacy rights or resources, and 3% restricted liberties. Finally, in terms of state legislated funding, the National Alliance on Mental Illness (NAMI) characterized state investment in mental health services as “slowing” in their comprehensive report on State Mental Health Legislation (2015).

Summary

It is the concept of stigma and the construct of structural stigma that could affect MHMI voting outcomes and create structural disadvantages for individuals with MHMI conditions, such as limited access and services. Throughout the policy process, legislators are in a position to either alleviate or perpetuate existing forms of structural stigma as well as create entirely new ones through their voting, bill sponsorship, or inaction. Thus, this dissertation aimed to examine what forms of structural stigma are currently active in MHMI state legislative proposals as well as how it affects related bill outcomes.

Policy Outcomes: Factors of Legislative Influence

Another core concept to this dissertation is the idea of legislative influence, specifically factors that influence the legislative process and its outcomes. Gamson (1992) defined influence as occurring when a behavior reflects a change that would not have been there without the efforts of the influencer. To my knowledge, past research has not yet explored factors that influence

MHMI voting behavior. However, the literature is robust in its exploration of legislative factors, both internal and external to the individual legislator, that have been shown to influence voting outcomes in general. The concept is explored further below.

Internal Influences

Internal influences of voting outcomes can be defined as influences that are characteristics of the individual legislator.

Ideology. One of the most consistent internal influences, as evidenced by historical voting outcomes, is ideology (Poole & Rosenthal, 2007). Ideology is the way in which an individual or a group rationalizes itself (Knight, 2006) and is molded by preferences based on past experiences. Haider-Markel (1999) suggested that if an issue becomes integrated into a legislator's existing ideological schematic, that schematic can guide their voting decisions. This idea holds true in the literature, as ideology has been found to be a significant predictor for voting outcomes (Kau & Rubin, 1979; Levitt, 1996), including on controversial issues such as abortion (Chressanthis et al., 1991) and the implementation of the Affordable Care Act (ACA; Shor, 2018).

In terms of mental health care, a legislator's opinion can be affected by personal experiences with family or friends, experiences with services, or stigmatic attitudes toward those in need (Trupin & Kerns, 2017). For example, Cohen et al. (2002) found that legislators who smoked tobacco were less likely to support policies related to tobacco regulation, while support was greater among those who had a close family member or friend die from smoking.

Demographic Characteristics. Also influential on voting outcomes are the internal demographics of policymakers, such as religion, gender, race/ethnicity, age, and education level. Religion plays a role in voting (Green & Guth, 1991; Oldmixon & Calfano, 2007; Washington,

2008) because it can inform what individuals classify as morally right or wrong (Oldmixon & Calfano, 2007), which affects political attitudes and voting outcomes (Wald, Owen, & Hill, 1988). Gender affects roll-call voting for economic policies (Hogan, 2008) and women's issue bills (Swers, 1998), and was associated with increased propensity for supporting policies related to social welfare (Poggione, 2004). Race was also associated with increased liberalism (Montgomery & Nyhan, 2017), and African Americans were more likely than Whites to sponsor bills on issues such as education or welfare policy (Bratton & Haynie, 1999). Finally, other miscellaneous demographics, such as age (generation) and education (level and type), significantly affected Latino legislators' voting behavior (Rocca et al., 2008).

External Influences

Also influencing voting outcomes are external influences, or influences that are not a legislator's personal characteristics.

Public opinion. Past research has found that public opinion affects policy decisions (Erikson, Wright, & McIver, 1993; Hill & Hinton-Anderson, 1995; Page & Shapiro, 1983; Wright, Erikson, & McIver, 1987), as legislators are motivated to pay attention to the public through their job as delegates (Butler & Nickerson, 2011) or to gain reelection (Kuklinski, 1978). The most common type of public opinion examined in the literature is a legislator's constituency, which also has been found to affect the legislative process (Bartels, 1991; Butler & Nickerson, 2011; Gay, 2007).

Political Party. A legislator's political party influences their vote (Cox & Poole, 2002; Davidson et al., 2013; Snyder & Groseclose, 2000). Political parties could be viewed as tangible representations of legislator ideology. Cox and McCubbins (1993) theorized that "The desire to create and maintain a favorable party reputation is sufficient motivation for legislators to

empower party leaders and to support policy outcomes that reflect the preferences of the median member of the majority party...” (pp. 35-36). For example, party affiliation has been found to be significantly associated with voting outcomes on social welfare (Barrett & Cook, 1991) and substance abuse issues such as tobacco control (Cohen et al., 2002).

Advocacy. According to Fowler and Hertzke (1995), advocacy can be generally defined as, “...any organized effort to influence the direction of public policy” (p. 53). Howe et al. (2010) further conceptualize advocacy as increasing awareness and educating a target audience on an issue, with the goal of achieving a specific result. Advocacy is key to all stages of legislative debate and has been found to be effective in influencing decision making in politics (Howe et al., 2010).

Interest groups. Using Fowler and Hertzke’s (1995) general definition of advocacy, one common form of political advocate is the interest group. Interest groups may play a critical role in elections and affecting health care policy outcomes (Weissert & Weissert, 2008). Legislators may work with interest groups to create legislation that could produce the campaign contributions and votes needed for reelection (Cho et al., 2008).

Research. Contributing to and influencing the policy development process are two main goals of research, and researchers play a critical role in that process (Goldstein, 2009). Research is an important tool in health policy outcomes because it can be used to identify problems, offer potential solutions to those problems, and forecast impacts of policy choices (Humphreys & Piot, 2012). Research evidence that supports the effectiveness of a proposed program or policy can aid in moving policy in an empirically sound direction (Trupin et al., 1989).

In terms of public health, informing action through science has been critical to its legislative history and foundation (Fielding et al., 2002), most notably in the areas of tobacco regulation and

HIV/AIDS. For example, structural and public stigmas surrounding HIV/AIDS have declined since the 1980s due to increased research that debunked misconceptions in the etiology of the disease (Clair et al., 2016). Medical experts shifted the blame from homosexuality and substance abuse to viral transmission, proving that anyone could contract the disease (Epstein, 1996). Scientific knowledge eased fears and opened up space for social reconstructions, such as framing the target population as blameless rather than at fault. As a result, federal, state, and local governments began to extend greater allocations in policy design, including greater access to services and newly legalized job protections (Schneider & Ingram, 1997, 2005).

Media. The media can also shape public opinion and affect voting outcomes. Media advocates often target policymakers and attempt to use the power of the media to influence policy change (Dorfman & Krasnow, 2014; Wallack et al., 1999). For example, the media brings attention to issues, which can change public opinion and force legislators to act (Buse et al., 2005; Sample & Kadleck, 2008). Sample and Kadleck (2008) noted that in their study, all legislator respondents relied on the media for information on events and statistical trends. Using the HIV/AIDS example, 60% of Americans said most of what they knew about the disease came from the media (Kaiser Family Foundation, 2011). Medical experts began to use the media to communicate their findings publicly and reduce myths surrounding the disease (Epstein, 1996), which shifted public opinion (Kaiser Family Foundation, 2011) and pushed legislatures toward funding for testing and prevention.

Finally, emerging research suggests that social media can be effective in fostering civic engagement (Boulianne, 2009), social movements (Carty, 2010) and voter mobilization (Haynes & Pitts, 2009); however, according to Bou-Karroum et al.'s (2017) systematic review, the extent

to which social media interventions can affect the policymaking process remains unclear and is understudied in the literature.

Significance of the Study

Contribution to the Literature

There have been attempts to examine structural forms of MHMI stigma in the past (Burton, 1990; Corrigan et al., 2005; Hemmens et al., 2002), but most research in the stigma field has examined the attitudes of the stigmatized individual rather than the structures that stigmatize them (Hatzenbuehler et al., 2013). Further, in their comprehensive review on measuring mental illness stigma, Link et al. (2004) identified structural forms of stigma as a critical gap in the research: "...we see the underrepresentation of this aspect [structural stigma] as a dramatic shortcoming in the literature on stigma, as the processes involved are likely major contributors to unequal outcomes for people with mental illnesses..." (pp. 515-516). Finally, there is a paucity in the research looking at how structural stigma—and legislative factors in general—may affect MHMI-specific voting outcomes. If the legislators themselves or the bills they introduce are stigmatized in their potential effect or language, they could be perpetuating the current lack of access and resources in mental healthcare.

Contribution to the Field

Social workers have repeatedly advocated for increased mental health funding and legislative assistance, but gaps in services persist. To have some effect on allocation and voting processes, mental health researchers and advocates must identify factors that influence key allocation decisions (Corrigan & Watson, 2003). Findings from this dissertation could assist both micro and macro mental health social workers in advocating for individuals with MHMI conditions, including their clients. Socially, this project can raise public awareness, including that of public

administrators, policymakers, and advocacy groups, on the presence of structural stigma in state legislatures and its impact on MHMI bill outcomes. Politically, understanding influences of MHMI bill outcomes provides critical information for structuring effective advocacy efforts (Corrigan et al., 2004). These findings will provide blueprints for advocates on which legislators to target for sponsorship, potentially leading to (1) a reduction in stigmatic bills introduced by state legislators, and (2) more effective advocacy efforts in addressing mental healthcare gaps.

Introduction Summary

MHMI initiatives are effective, yet most do not receive treatment. Policy implementation at the legislative level could help to close gaps in access and services, but valuable legislation often does not pass, potentially due to structural stigma. Understanding what forms of structural stigma are present in legislatures as well as what factors influence bill outcomes could help social workers be more effective in their advocacy efforts to close gaps in mental healthcare. Thus, the purpose of this dissertation was to examine what forms of structural stigma are currently active in MHMI bills as well as how stigma and other factors may affect bill outcomes.

Chapter 2: History and Theory

Behaviors are classified as normal or abnormal based on context, which is often a function of time and culture (Farreras, 2017). Abnormal behaviors in particular are considered abnormal because they tend to deviate from the norms of a certain period or culture. Historically, if individuals displaying abnormal behaviors were associated with a time period's definition of mental illness (MI), they often were met with labeling, stereotyping, status reduction, separation, and/or discrimination. As explorations into the past frequently lead to increased understanding of the present, the beginning of Chapter 2 offers a brief, yet comprehensive summary of how people with MI have been stigmatized throughout history, using examples across time and place.

History of Mental Illness

According to Farreras (2017), theories regarding the etiology of MI, or abnormal behaviors associated with MI, have permeated history and can be categorized as supernatural, somatogenic, or psychogenic. These etiological theories of MI have determined the treatments that individuals with MI have received over time (Farreras, 2017). While the theoretical categories have remained consistent and have been recycled in numerous ways throughout history, the validity of the scientific attributions and the humanity of the subsequent treatments vary widely.

6500 BC- The Dark Ages

Supernatural

Supernatural theories attribute MI to possession of the individual by demonic spirits, curses, or sin. One of the first supernatural interventions to alleviate suffering related to MI was trephination. This treatment consisted of surgically drilling into the skull to allow trapped evil spirits to escape, and evidence of the treatment has been found in human skulls and depicted in prehistoric cave art dating back to 6500 BC (Faria, 2013; Restak, 2000). It is assumed that some

of the first ancient individuals to be treated with trephination were criminals, all of whom were considered to have some sort of MI and were treated as outcasts, tortured, or killed (Farreras, 2017).

Other early civilizations attributed ‘madness’ to animalistic spirits; insanity was thought to be caused by ‘wolf-madness’, and symptoms included traversing graves and howling at the moon. Those with what is now called depression were thought to have the ‘black dog’, caused by disobeying the teachings of gods and priests (Porter, 2002).

Certain religions also viewed MI as caused by the supernatural. In early Christianity, ‘madness’ was believed to be a punishment from God for wrongdoing, and the intervention of choice was exorcism to rid the individual of evil spirits (Gosselin, 2017), the effectiveness of which may still be widely believed among certain groups around the world (Mercer, 2013). Further, Muslims traditionally viewed ‘jinn’, or supernatural creatures, as a cause of MI or epilepsy (Lim et al., 2015). According to Porter (2002), most religions and cultures around the world have embraced views of demonology at some point in time.

Somatogenic

Somatogenic theories identify disturbances in physical functioning as causes of MI, including physical illnesses, brain imbalances, or genetic abnormalities. One of the first somatogenic theories, introduced by Chinese medicine (2700 BC), was the idea of ‘yin and yang’, or complimentary bodily forces that attributed mental or physical illness to an imbalance between these forces (Tseng, 1973). Further, in Mesopotamia and Egypt, women suffering from MI were thought to be experiencing a wandering uterus, otherwise known as hysteria in Greece. As somatogenic treatments, the Egyptians and Greeks used strong-smelling substances to direct the uterus back to its proper place in the body (Farreras, 2017).

Physicians in Greece rejected the supernatural and embraced somatogenic explanations of MI. For example, around 400 BC, Hippocrates (the father of medicine; 460-357 BC) sought to separate religion and superstition from medicine by suggesting that mental and physical illness were actually caused by an imbalance in an essential bodily fluid, or humor (i.e., black or yellow bile, phlegm, or blood) (Farreras, 2017). MI was classified as either brain fever, epilepsy, melancholia, or mania; the latter two were broad terms covering many disorders, such as depression, psychoses, and schizophrenia (Dalfardi et al., 2014).

Rather than faulting the individual and attributing MI as spiritual punishment, the somatogenic theories of this time period transferred accountability from an individual's actions to their inherent biology. This change reduced societal blame directed toward individuals with MI and was reflected in the increased humanity of their treatment (Farreras, 2017). For example, Soranus of Ephesus, another Greek physician living in the second century AD, was a practicing Methodist (school of medicine, as opposed to religious denomination) and based his treatment on the presence or absence of certain biological features or traits (Gosselin, 2017). Soranus and other Methodists were non-traditional and believed in holistic care, treating the whole of the patient with compassion. Further, creatives who were considered to be suffering from melancholia, including poets and artists such as Plato (427-347 BC) and Aristotle (384-322 BC), were actually admired and celebrated by leaders. This paradox of 'madness versus creative genius' still exists today (Gosselin, 2017).

Psychogenic

Psychogenic theories attribute MI to trauma, stress, distorted perceptions, or maladaptive thoughts and actions. Galen (130-201 AD), another prominent Greek physician, added to Hippocrates's work by introducing the notion of psychogenic explanations for MI, including

stress. However, his theories were ignored for centuries in favor of physical causes (Farreras, 2017).

In the period known as the Dark Ages (i.e., the centuries following the fall of the Roman empire in 476 AD), historical records regarding societal views and treatments of MI are limited. However, during the 10th century, a Persian physician named Al-Akhawayni Bukhari classified what was known as melancholia into three groups that have been compared to current DSM-5 disorders. Treatments included plants and vegetables, such as cucumber, fennel, and celery, to be used as medication for MI management (Dalfardi et al., 2014).

The Middle Ages- Present

Supernatural

While not as widely used, supernatural theories and treatments were still evident in this time period, especially during the Middle Ages. From the 11th-15th centuries, supernatural explanations for MI again began to dominate in Catholic and Protestant countries (Farreras, 2017). Abnormal behaviors were attributed to witchcraft and/or demonology, and individuals with MI were accused of having committed crimes or sinful offenses under the devil's influence due to weakness, sickness, or lack of willpower (Gosselin, 2017). Most notorious was the infamous witch hunt, which started in the 1400s and claimed millions of lives over a 250-year period (Cavanaugh, 2015). In the 16th century, Johann Weyer and Reginald Scot attempted to combat the witch hunt by suggesting that the accused were actually women with melancholy, or depression (Farreras, 2017). Weyer in particular is recognized as the first physician to specialize in treating melancholy (Cavanaugh, 2015) and is credited as the founder of modern psychiatry (Gosselin, 2017). Weyer and Scot opposed the punishment of accused witches, noting that most

confessions were taken during torture (Gosselin, 2017). However, the pair had limited success, as their writings were banned by the Church's Inquisition (Farreras, 2017).

During the 17th and 18th centuries, confinement was used as a way to control individuals with MI (Gosselin, 2017). Poorer citizens were placed into public houses of charity (Almshouses) or jailed. The Roman Catholic Church and the Church of England brought back exorcism rituals dating back 1000 years before, as society viewed fear as the best way to restore minds to reason (Mercer, 2013). Individuals with MI were treated as animals who did not have the capacity for control and were capable of living in terrible conditions without complaint, due to their physical insensitivity to temperature or pain (Farreras, 2017).

At present, supernatural theories have once again experienced a recent resurgence as mental health treatments (Gosselin, 2017). For example, Pentecostalism highlights the supernatural as a cause of MI, but also relies on supernatural entities for treatments, which include divine healing, miracles, and exorcism. Pentecostalism is the fastest-growing movement in Christianity (Miller, 2006), as over 80 million Pentecostals were living in the US in 2013 (Mercer, 2013), including the majority of the American Latino population (Espinosa, 2014).

Somatogenic/Psychogenic

While supernatural theories have stood the test of the time, the majority of treatments after the Dark Ages were somatogenic, psychogenic or a combination of the two, as the fields of psychiatry, psychology, and sociology began to modernize. During the Middle Ages and Renaissance periods, madness or MI was considered the reverse of wisdom, or a state of unreason (Gosselin, 2017), and individuals with MI in Europe were confined to hotels for the insane (Foucault, 2009). In 1247, Bethlem Hospital in London housed the first institution created

solely for the treatment of people with MI, but also inserted itself into the “shows of London” where patients were on display to the public, similar to a human zoo (Porter, 2002).

More modernized public treatments of MI began in the 16th century with the organized establishment of hospitals and institutions, otherwise known as asylums (Farreras, 2017). Their missions were to separate and confine all undesirable individuals (e.g., vulnerable populations resulting from economic depression and war) and separate them from society. Confinement laws focused on protecting society from these ‘undesirables’, so governments were given the responsibility of an inmate’s food and housing in exchange for their personal liberty, similar to the treatment of modern-day criminals. Akin to Bethlem Hospital, inmates were widely institutionalized against their will, chained to the walls in filth, and exhibited to the public for a fee, like circus animals. Treatments were somatogenic in nature, such as bleedings and purges, which were similar to treatments for physical illnesses during the time period (Farreras, 2017). Confined and restrained commitments became justified under policies that made it illegal to have a MI or to be homeless (Gosselin, 2017), and between the 16th and 18th centuries, the housing of people with MI often fell to jails (Bynum, 1981). Prison records of the time labeled inmates as mad, imbeciles, weak in the mind, simpletons, and malformed (Foucault, 2009). In England’s Vagrancy Act of 1744, any person could claim and detain someone as a lunatic, and the decision to release the person fell to the jailers or magistrates (Gosselin, 2017).

Privatized, for-profit asylums became popular and affordable in the late 1600s and were viewed as byproducts of the increase in wealth and the undesirability of keeping people with MI in homes (Gosselin, 2017). At this time, anyone could open a private asylum and receive payment, independent of any restrictions or regulations. England’s Madhouse Act of 1774 was the first law that required licensure for private asylums and certificates for patients (Bynum,

1981), but the act did not include stipulations on proprietor qualifications or treatment standards. Doctors knew little about the pathology of MI, yet could sign these certificates for insanity, regardless of their specialty (Gosselin, 2017). Lives were ruined, regardless of evidence; insanity charges resulted in loss of liberty and property, and even acquittals decreased their community status and reputation (McCandless, 1981). By 1850, the majority of people with MI in England were housed in these privately owned institutions (Gosselin, 2017).

In the 1700s, the psychiatric profession began to advance (Busfield, 2015). The neurological school of psychiatry was formed by George Cheyne and others, who believed that health was easier to preserve rather than cure (Cheyne, 2013). The origins of madness began to be studied and scrutinized by the scientific community, and researchers began to find links between MI, physical illness, and drug use (Gosselin, 2017). Scientists used both somatogenic and psychogenic explanations to rationalize MI; problems were attributed to either physiological defects of the nervous system (Gosselin, 2017) or psychological conditions that influenced behaviors (Porter, 2002). Individuals with MI were looked after by family members or sent to private ‘madhouses. While these philosophies seem more humanistic, homecare was horrific and included chains, pigpens, and dark basements (Shorter, 1997). Families who did not understand the behaviors of their relatives once again reverted back to demonological beliefs (Gosselin, 2017).

During the late 18th and 19th centuries, the somatogenic versus psychogenic debate over the origins of MI continued. Some European scientists viewed MIs as neurological conditions, while others viewed them as traits that varied, depending on the individual (Farreras, 2017). For example, Franz Mesmer attributed symptoms of hysteria to imbalances of magnetic fluid, due to recent findings in electricity (Forrest, 1999). In contrast, Jean-Etienne Dominique Esquirol’s

Mental Maladies (1838) suggested psychological diagnoses, including affective disorders and pyro-, klepto-, and nymphomanias. Also during this time, former patient Clifford Beers used the introduction of Pasteur's germ theory and the discovery of vaccines as catalysts to lead the mental hygiene movement and became a well-known advocate for mental health. Lastly, James Braid, Josef Breuer, and Sigmund Freud treated hysteria through hypnosis, providing the blueprints for psychoanalysis during the first half of the 20th century (Farreras, 2017).

A more humanitarian view of MI also began during the 18th and 19th centuries, over protests concerning living conditions. In France, Philippe Pinel (1745-1826) and his former patient Jean Baptise Pussin called for "traitement moral" at hospitals, which included improved living conditions, the freedom and unshackling of patients, and physical activity on hospital grounds (Micale, 1985). Around this same time, religious and morality concerns in England were the catalyst for more humane treatments. In 1796, at the urging of William Tuke, the York Retreat was established, where the standard of care was dignity and respect, and patients were guests rather than prisoners (Bell, 1980). Also, John Conolly's 1856 book *The Treatment of the Insane without Mechanical Restraints* publicly advocated for the moral treatment of people with MI by feeding them like humans and eliminating the use of shackles and small crates as restraints. The York Retreat became the model for new private asylums in America, and psychogenic treatments (e.g., compassionate care and physical labor) gradually began to replace outdated somatogenic treatments (e.g., gyrators and tranquilizer chairs) (Grob, 1994). However, during the second half of the 19th century, the morality movement was largely overshadowed by negligence due to overcrowding of asylums. Activist Dorothea Dix recognized this growing problem and advocated for the creation of state hospitals, helping to establish over 30 in Canada and the United States (Viney & Zorich, 1982).

During the first half of the 20th century, Hollander's (1916) *Nervous Disorders of Men* demonstrated that SMI had increased sharply from 1860 to 1913, due to intensified brain activity as a result of the progress of civilization. He argued that nervous conditions were socially induced and that MIs were disorders of psychological dysfunction, rather than organic diseases (Gosselin, 2017). Following the invention of the first psychotropic medications in the mid-20th century, the pharmaceutical industry gradually replaced the somatogenic treatments of the time (e.g., electro-convulsive shock therapy and lobotomies) and began treating MI as a chemical imbalance in the brain. Also during this time, psychoanalysis became the dominant psychogenic treatment for MI, which created a foundation for today's psychotherapy (Farreras, 2017).

Currently, both somatogenic and psychogenic theories are applied today, as most modern clinicians utilize client-centered, behavioral, cognitive-behavioral, and/or psychodynamic approaches, with individual, family, or group applications. Social workers in particular often use a combination of the two in their work, most notably the biopsychosocial model, which suggests that individuals may be born with genetic predispositions for certain MIs, but that specific psychological stressors need to be present for the MI to fully develop (Farreras, 2017). Other sociocultural variables, such as poor living conditions, economic disparities, sociopolitical unrest, difficult personal relationships, and/or social inequalities, may also be contributing factors to developing MI. While societal explanations and responses to MI have progressed, treatments continue to reflect the same underlying theoretical influences recycled throughout the history of MI (Farreras, 2017).

Diagnoses

According to Farreras (2017), the historical progression of MI attribution and treatment theoretically implies a progression in MI diagnosis. A diagnostic classification system with

standardized definitions of MIs assists in creating a shared language among providers and researchers. The Greeks were the first to recognize diagnoses, but German psychiatrist Emil Kräpelin was the first to publish a symptom-centered (i.e., syndrome) classification system. Others developed their own unique classifications, including the previously mentioned *Mental Maladies*, which created a need for a single, shared system. Thus in 1952, the American Psychiatric Association published the first Diagnostic and Statistical Manual (DSM), which is now regarded as the standard language for MI diagnosis. The DSM aides in research, provides a shared language for clinicians, and perhaps most notably, allows for reimbursement by insurance companies. DSM critics point to its Westernized reliance on the medical model as well as the sharp increase in diagnosed disorders, partially due to the requirements of insurance companies. Diagnoses have tripled since 1952, and almost half of Americans will receive a diagnosis in their lifetime, potentially leading to further labeling and stigmatization of individuals with MI (Farreras, 2017).

Historical Summary

Using Link and Phelan's (2001) definition, the history of MI treatment suggests that most societies had a stigmatized view of people with MI, regardless of time and place. For example, individuals with MI were labeled as imbeciles, simpletons, undesirables, and witches, and were stereotyped to be dangerous, possessed, or criminal. They experienced separation and status loss by being removed from society, shackled against their will, and treated like animals for the public's viewing pleasure. As any doctor could sign certificates of insanity, and any citizen could claim and detain someone as a lunatic or open up their own for-profit asylum, individuals with MI frequently endured discrimination, which often resulted in loss of personal liberty and property. Finally, people with MI were exposed to treatments such as trephination, exorcism,

bleedings and purges, gyrators, tranquilizer chairs, shock therapies, and lobotomies, often in places such as pigpens, basements, or jails. While society has made breakthroughs in treatment for MI, many of the underlying stigmatization still exists today. As the first half of Chapter 2 has discussed the ‘what’ in terms of what has happened historically to people with MI, the second half of Chapter 2 will present theories that assist in explaining the ‘why’.

Theoretical Framework

Traditionally, the public policy process and its voting outcomes can be explained in the literature theoretically (e.g., agency theory, rational choice theory, diffusion theory, multiple streams theory). However, while these theories address the legislative process, additional attention needs to be paid to the role of stigma within that process, as policy introduced by stigmatized policymakers may also be stigmatized. Thus, the second half of Chapter 2 presents and discusses theories that assist in explaining the existence and persistence of MHMI stigma, including its potentially structural consequences via the policy process.

Symbolic Interactionism

Symbolic interactionism (SI), a theoretical perspective first introduced by George Herbert Mead (1934), attempts to explain the nature of social interactions and their effect on reality. Propositions include assertions that (1) individuals are capable of thought shaped by interaction, (2) both reality and meaning are socially constructed, (3) these realities and meanings can change based on interpretation and experience, and (4) individuals have the ability to assume the perspective of other individuals or the community-at-large (the generalized other) and judge their own actions accordingly. SI suggests that individual actions can be understood in context of the actions of the larger social group to which they belong. Individual actions are a part of greater

social actions that go beyond the individual and can implicate or affect other members of the social group (Mead, 1934).

SI provides a deeper understanding into why policymakers may have similar beliefs to the general public (generalized other) regarding MHMI. Along with the general public, legislators are members of a larger social group (society) and are exposed to the same attitudes of the whole community as the citizens they serve. Therefore, according to SI, if a 'generalized other' holds stigmatizing attitudes toward people with MHMI conditions, these attitudes would influence individual behaviors, including those of legislators. Understanding that legislators are a part of a larger society and that their realities and meanings are socially constructed, and potentially stigmatized, provides a foundation and justification for this dissertation's investigation.

Erving Goffman (1963) expanded on Mead's SI by applying it to the concept of stigma and stigmatized conditions (MHMI, race, blindness, deafness, etc.). Goffman introduced the idea of social identity, or the collection of attributes and statuses that individuals collect themselves and encounter in others. He posits that social identity can be virtual or actual. Virtual identities are projections or inferences about an individual made by others before meeting. Attributes and characteristics are assigned to an individual in anticipation of an encounter. Actual identities are who individuals really are, composed of authentic, legitimate attributes and characteristics. Differences between the two, or differences between assumptions versus reality, can create incongruence. For individuals with MHMI conditions, incongruence can cause stigmatization through either discredited or discreditable stigma. Discredited stigma occurs when a 'difference' is visible (e.g., diagnosis or impairment), while discreditable stigma occurs when a 'difference' is hideable or unknown (Goffman, 1963). Policymakers who stigmatize may do so because of

incongruence between virtual and actual social identities of people with MHMI issues, created by a stigmatized ‘generalized other’.

Social Constructionism

As described earlier, one of the core propositions of SI is that both reality and meaning are socially constructed (Mead, 1934). Every society has norms and values that guide what is acceptable and what is not in terms of behaviors and attributes. Social constructionism is a sociological theory suggesting that social reality—including its norms and values—is constructed through the social interactions of humans (Berger & Luckmann, 1966). Social constructions are viewed as stereotypes about certain groups, influenced by a wide variety of societal entities, such as politics, history, socialization, culture, the media, religion, etc. (Schneider & Ingram, 1993). Constructions are created when societal actions are frequently repeated and become patterns (habitualization), which are then accepted as consensus and become societal norms (institutionalization). Meanings of phenomena are positively or negatively constructed, not necessarily based on the phenomena themselves, but rather through human interactions surrounding them. As a result, humans understand their worlds based on these socially constructed norms; their reality has become institutionalized through their own habits and the habits of those before them (Berger & Luckmann, 1966).

Social Construction of Stigma

Ainlay et al. (1986) suggest that members of society hold shared views (norms) about normal versus abnormal behaviors, which dictate the nature of stigma and societal attitudes about its different forms. Members of society who don’t conform to these norms may be viewed as possessing “...some attribute that conveys a social identity that is devalued in a particular social context” (Crocker et al., 1998, p. 505) and could be categorically discounted from ‘normal’ to

‘deviant’. According to Goffman (1963), stigmatization occurs when societies mark, label, or brand people as deviant or less than, based on these socially constructed norms. While stigma arises from an attribute or behavior considered deviant when compared to social norms and may exclude the stigmatized from full participation in society, it can be created and maintained only through social interactions (Goffman, 1963). As a result, stigmatization is subjective; a person’s worth is determined based on generalized perceptions, rather than objective criterion (Conner et al., 2010).

One of the most common forms of stigma surrounds the socially constructed concept of illness. Here, meaning is grounded in how society views the conceptual distinction between disease (the biological condition) and illness (the social meaning behind the condition; Eisenberg 1977). The scientific method assesses symptoms and diagnoses individuals into disease designations or categories of deficit (Walker, 2006). These categories are considered either normal or abnormal, each with societal connotations. A social constructionist would suggest that there is nothing inherently stigmatizing about these conditions; however, societal responses to conditions and the type of individuals who suffer from them can provide a distinction between a condition and a stigmatized illness (Conrad 1987). MIs, in particular, are defined by symptoms, and those who have these symptoms are diagnosed and labeled as abnormal, despite the fact that societal norms only persist through societal agreement (Walker, 2006). As a result, society attaches socially constructed assumptions or attributions to people labeled with mental illness; this process is discussed further below.

Attribution Theory. Attribution theory, introduced by Heider (1958), discusses how an individual’s attribution of responsibility for—and controllability of—a condition can influence their assessment (Goffman’s virtual identity) of another. In essence, individuals have internal

motivations to discover causal relationships of actions and behaviors. In their attempts to discover causality, people make attributions about the controllability and stability of life, including the responsibility of the actor for their own actions (Weiner, 1980). In terms of MHMI, the public makes attributions about the controllability and cause of a mental illness, leading to perceptions and inferences about an individual's responsibility for their own illness. These inferences then lead to reactions that can either be protective or punishing (e.g., stigmatic).

Legislator actions are impacted by their beliefs in terms of the stability and controllability of mental illness. In terms of stability, if policymakers believe the stereotypical attribution that MHMI issues are unlikely to change or improve, then they may prioritize other issues when allocating funds. In terms of controllability, if legislators believe that individuals are able to control their ability to cope with their illness and are thus responsible for their own conditions, then they may be more likely to blame the individual and again, direct their fiscal allocations elsewhere. Essentially, attributions of causality, stability, controllability, and responsibility can affect a legislator's decision making on funding decisions or the language and potential effect of their legislative proposals.

Modified Labeling Theory. Labeling theories were first developed in the areas of crime and deviance (e.g., Durkheim, 1897; Becker, 1963), and Mead's (1934) symbolic interactionism also influenced their ongoing development. However, Scheff (1966) first explored at length the relationship between labeling and MI. Scheff suggested that being labeled 'mentally ill' would powerfully affect societal reactions toward individuals receiving the label. Further, in modified labeling theory, Link and colleagues (1989) constructed a framework for understanding the processes and consequences surrounding MI labeling and stigma. First, as a part of the socialization process, individuals develop conceptions of MI based on their perceptions of

commonly held beliefs in society (similar to Mead's generalized other). Once solidified, these conceptions become lay theories comprised of assumptions about what it means to have a MI and what all people with MI must be like (a kind of collective virtual identity). If these societal beliefs regarding MI are stigmatized, it follows that the assumptions of each individual may also be stigmatized. As a result, individuals who are treated for MHMI conditions and receive an official label (psychiatric diagnosis) or an informal label (psychiatric patient) may experience stigmatizing attitudes by the public and/or themselves (self-stigma; Link et al., 1989).

Theories of labeling may be applied to policymakers in several ways. First, legislators are members of the general public, and according to modified labeling theory, they generally would be socialized with similar attitudes and beliefs as the general public. Therefore, because MHMI is still a stigmatized issue, legislators may endorse negative stereotypes, which may lead to discriminatory decision making (e.g., funding, voting, or sponsorship) on issues that affect individuals carrying MHMI labels. Second, when authoring or sponsoring bills, policymakers may use MHMI labels in the language. Building stigmatized labels into current law may reinforce stereotypes that are already endorsed in the general public and further perpetuate the cycle of MHMI stigma.

Social Construction of Target Populations

Stigmatized individuals that have been socially constructed as abnormal or deviant can be integrated together into stigmatized groups (Ainlay et al., 1986). Policymakers construct laws, policies, and other structures to reflect the negative connotations attached to these stigmatized groups (Frost, 2011). For example, legislators may not allocate funds or vote in favor of an MHMI-related bill because they see people with mental illness as less-than. One theory that

seeks to explain the connection between the social construction of groups and its effect on public policy results is the social construction of target populations.

The social construction of target populations (SCTP) is a framework for considering the complex relationships between social constructions, policies, and power (Schneider & Ingram, 1993; Schneider et al., 2014). Schneider and Ingram (1993) define SCTP as "...the cultural characterizations or popular images of the persons or groups whose behavior and well-being are affected by public policy" (p.334). Target populations are certain groups in the policy arena that receive benefits or burdens and are considered favorable or unfavorable, based on how they are socially constructed (Schneider & Ingram, 1993). The construction of target populations impacts which issues get addressed, move up on the policy agenda list, or get left behind (Schneider et al., 2014). For example, on issues related to physical health, policies targeting positively constructed populations have a higher likelihood of receiving public or legislative support than those policies targeting unfavorable populations, such as individuals with obesity or HIV/AIDS (Donovan, 1993; Husmann, 2015). Overall, SCTP is useful because it assists in understanding who benefits from policy change and why, including providing a theoretical explanation as to why policymakers may support certain policies over others (Ingram & Schneider, 1993).

Schneider et al. (2014) organize SCTP into five distinct propositions:

1. Whether target groups are benefitted or burdened by policy depends on the extent of their political power and their social construction. In their research, the authors proposed four distinct categories of target populations that differ in power and their perceived deservedness of policy support:
 - a. The advantaged are politically powerful and positively constructed populations, allowing them to receive beneficial policy support;

- b. contenders are politically powerful, but are viewed as undeserving of policy support because of their negative construction;
 - c. dependents are positively constructed groups with little power, little resources, and poorly funded policies; and,
 - d. deviants are perceived as unworthy and have very little political power; they often become the target of punishing policies.
2. Policies have material and symbolic impacts on target populations that impact attitudes and political participation.
3. Social constructions emerge from intuitive and emotional judgments and are sustained through justifications made with selective attention to evidence. Policymakers then respond and exploit these social constructions in the rationales and designs of policies through phenomenon such as availability heuristics or confirmation bias. Availability heuristics are mental shortcuts made in decision making where judgments are based on how easily things come to mind (e.g., the social constructions of groups that have become societal norms). In addition, confirmation bias is the tendency to pay attention to evidence that confirms what the policymaker already believes. Judgments and decisions are made primarily based on subjective thoughts or beliefs, rather than objective reason or deliberation.
4. Social constructions of target populations can change, and policy is an important catalyst for that change. Shifting constructions are often found in the unintended or unanticipated consequences of previous policy.
5. Types and patterns of policy changes can vary based on the social construction and power of target populations. For example, any burdens imposed upon advantaged groups will be

met with increased resistance due to their positive social construction and increased power (Schneider et al., 2014).

SCTP's five propositions interact with each other. Marier et al. (2014) note that policies usually reinforce existing power relations between groups, but the potential for change may occur, depending on the circumstances. For instance, shifts in the social construction of target groups and changes in policies can mutually influence each other. New or amended policies can create opportunities for previously disadvantaged groups to gain power and/or develop a more positive social construction, which in turn can lead to additional policy changes and increased benefits distributed to these groups. An accumulation of benefits over time can result in groups obtaining an 'advantaged' position (Schneider & Ingram, 2005). For example, as mentioned earlier, stigma surrounding HIV/AIDS has declined since the 1980s (Clair et al., 2016). This is partially due to the social reconstruction of HIV/AIDS, resulting from scientific breakthroughs and stories like Ryan White, a 13-year-old banned from his classroom for contracting HIV/AIDS. His story added a civil rights dimension to the societal narrative that resulted in positive media coverage, public opinion transformation, and increased target population power (Schneider & Ingram, 2005). This led to new policies that created additional opportunities for individuals with HIV/AIDS, most notably the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, which sought to improve access to care for vulnerable populations.

Policy Design Theory

While societal norms, concepts of illness, and target populations can all be socially constructed and affected by stigma, so can the policy design process. In the HIV/AIDS example above, because of the increased power and positive social reconstructions of the HIV/AIDS

target population, policy design benefits began to increase with increased support, while policy burdens began to decrease or face increased opposition, making their passage difficult. Policy design theory (PDT) seeks to explain the connection between the social construction of target populations and its effect on the actual design of public policy.

Policy design theory (PDT) was developed by Schneider and Ingram to examine interactions between policy designs and societal distributions of benefits and burdens (Schneider & Ingram, 1993; 1997). PDT argues that social problems are not neutral or objective, but are instead viewed as interpretations of conditions (Ingram et al., 2007), and according to Mettler (1998), social welfare policies in particular illustrate to the public which groups are important and which are not. For example, women and men of color were treated as second-class citizens in policies written during the New Deal (Mettler, 1998).

Similar to SCTP, a main characteristic of PDT is its focus on the relationship between social constructionism and public policy when examining social problems; however, PDT puts additional weight on the study of policy development and is policy-centered rather than population-centered (Soss et al., 2007). Policy design theorists believe that how social problems are constructed can influence the design of policies written to address them (Schneider & Sidney, 2009), including the types of policy solutions offered in the language (Schneider & Ingram, 2005). Specifically, PDT posits that the social construction of overall populations leads to the social construction of policymakers—including their acquisition and utilization of knowledge—which in turn leads to a socially constructed policy design.

Schneider and Ingram (1997) specifically define policy design as “the content or substance of public policy- the blueprints, architecture, discourses, and aesthetics of policy in both its instrumental and symbolic forms” (p. 2). It is important to note that PDT focuses not only on the

explicit, technical functions of policies (instrumental forms), but also on their implicit meanings and values (symbolic forms). Policy design includes several components, including (1) the social problem and solutions/goals; (2) the target population and its social construction; (3) the distribution of benefits and burdens to that target population; (4) policy tools to help achieve those distributions; and, (5) an implementation plan (Schneider & Ingram, 1997; Schneider & Sidney, 2009). Target groups can be affected differently based on these elements of policy design, as policies can have direct consequences (Mettler & Soss, 2004; Mettler & Stonecash, 2008).

PDT considers inequality among groups (Schneider & Ingram, 1997). Similar to SCTP, policy designs for advantaged populations focus on distributing benefits (e.g., capacity building) in order to align with national interests, whereas most of the policy directed at deviant populations consists of burdens or costs, depending on how groups are socially constructed (Ingram et al., 2007). Policy design scholars consider policy outcomes in their research and seek to further develop the relationship between policy design components and the populations they affect (Schneider & Sidney, 2009). PDT was tested in Donovan's (1993) study, where the author analyzed the target population (individuals with HIV/AIDS) as well as other relevant groups in the Ryan White CARE Act. PDT was supported, as he found that funding levels were proportionate to the social constructions of individuals with HIV/AIDS, rather than the actual number of people diagnosed (Donovan, 1993).

Theoretical Summary

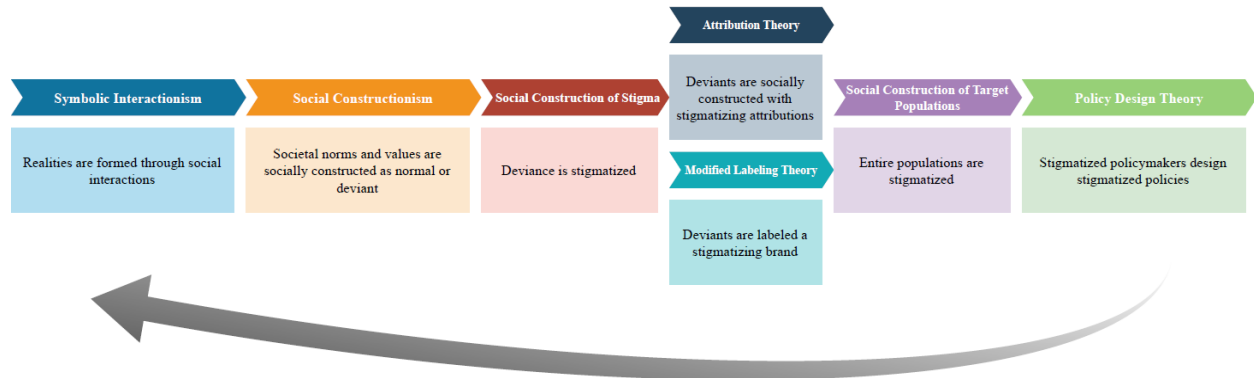
The theories above suggest a process linking symbolic interactionism to policy design theory (Figure 2). Social realities and meanings concerning certain phenomena are positively or negatively socially constructed, not necessarily based on the actual phenomena, but rather

through social interactions surrounding them. These social constructions become stereotypes about certain groups that form when societal attributions or actions are repeated and become patterns that become accepted as shared societal norms. These norms include shared societal attitudes about what is normal versus abnormal, which dictate the nature of stigma. In the policy world, socially constructed individuals may be grouped together as target populations that are viewed as favorable or unfavorable and receive benefits or burdens, based on the social construction of policymakers and their designs.

The current study is interested in what happens when a stigmatized population, such as people with MHMI conditions, is introduced into this process. Historically, realities and meanings surrounding people with MHMI conditions have been socially constructed as negative. People with MHMI conditions displayed behaviors that were considered deviant or less than, based on institutionalized social norms, and were labeled as such. Negative social constructions became stereotypes due to repeated attributions surrounding dangerousness, unpredictability, chronicity, controllability and cause, and degree of responsibility. A society or generalized other that has adopted the meanings behind these labels and attributions as its reality is a society that has adopted a stigmatized social construction of people with MHMI conditions. As policymakers are a part of society and the generalized other, they may also hold stigmatizing social constructions of people with MHMI conditions and burden them as an entire target population through their stigmatized policy designs or unfavorable voting. As law shapes social interaction, building MHMI stigma into law may begin this entire process again, as social realities and stereotypes already endorsed by the general public would be affirmed and reinforced through stigmatizing policy. The theoretical journey from the creation of social realities to a stigmatized MHMI policy process is illustrated below in Figure 2.

Figure 2

Theoretical Framework: Linking Social Construction to Policy Design



Purpose of the Study

Past empirical research and multiple theoretical perspectives suggest that the concept of MHMI as well as the policies and policymakers affecting the MHMI healthcare system may be socially constructed as stigmatized, which could affect policy outcomes. Further, there could be unique factors that influence voting behavior on issues that are stigmatized. Thus, the proposed study first seeks to describe and explore the nature of structural stigma present in state legislative proposals related to MHMI by operationalizing the construct into two variables: stigma present in the language of the bill and stigma present in the potential effect of the proposal. Second, the study seeks to examine the relationship between state legislative factors (including structural stigma) and bill outcomes, in order to disseminate any patterns or predictors and improve advocacy efforts surrounding MHMI services and access.

Chapter 3: Methods

This chapter presents the methodology of the study. The chapter begins by solidifying the research questions that guide the overall inquiry and presenting the research design, including an in-depth description and rationale of the choice. Next, the procedures involved in data collection, sampling, and the operationalization of the variables are provided. The chapter concludes with a discussion of the data analysis plan and a description of its execution.

Research Questions

The current study sought to examine structural MHMI stigma in state legislatures and determine factors that influence MHMI policy outcomes. While legislators may not always be involved in the writing of the proposals they introduce, their sponsorships are the legislative embodiment of their attitudes, and examining proposals as artifacts can increase our understanding of how structural stigma manifests in the MHMI policy process. Thus, based on the previously discussed social problem and gaps in the literature, the following are the research questions for the current study:

1. What is the nature of structural stigma in state MHMI legislative proposals?
 - a. To what extent is stigma present in the language of state MHMI legislative proposals?
 - b. To what extent are the potential effects of state MHMI legislative proposals structurally stigmatic?
 - c. Do sponsor, institutional, or bill-related factors affect or predict the introduction of structurally stigmatic proposals?
2. How do sponsor, institutional, or bill-related factors influence state MHMI legislative outcomes?

- a. Do sponsor demographic factors affect or predict state MHMI legislative outcomes?
- b. Do institutional factors affect or predict state MHMI legislative outcomes?
- c. Do bill-related factors affect or predict state MHMI legislative outcomes?

Research Design

This study used quantitative content analysis (QCA) to explore and describe state MHMI legislative proposals in order to better explain and predict subsequent legislative outcomes. Overall, this dissertation adopted the following steps referenced in the literature as critical to a rigorous CA's research design: (1) state the problem, (2) review the previous literature, (3) formulate and clarify research questions of merit, (4) clarify the study research design, (5) discuss the procedure, including the sample characteristics and data collection, (6) detail coding and data analysis, and (7) discuss results and provide implications (Drisko & Maschi, 2015; Krippendorff, 2004). Steps 1-3 have been discussed previously, while steps 4-7 will be discussed below.

Rationale & Description

QCA was used to systematically, objectively, and transparently codify content from textual data in order to describe and quantify conceptual phenomena (Downe-Wamboldt, 1992; Krippendorff, 2013). QCAs can differ in purpose, type, and content, depending on the research question (Gaur & Kumar, 2018; Rose et al., 2015), so below is a discussion of what was used in this dissertation as well as clarifications as to why.

Purpose and Type

The ultimate aim of this dissertation was to summarize and predict legislative outcomes (quantitative) rather than search for themes in the bills (qualitative). Therefore, QCA was used to

transform textual data into frequencies that were summarized and utilized statistically (Krippendorff, 2004; Neuendorf, 2002). However, while the research design was quantitative overall, skills and techniques from both methodologies were used, as is often the case in rigorous CAs (Weber, 1990). Specifically, qualitative, textual data from state MHMI legislative proposals were quantitatively summarized through the coding process to create frequencies for statistical analysis.

This QCA was empirically grounded, exploratory in process, and predictive in intent. Guided by the QCA literature (e.g., Drisko & Maschi, 2015; Krippendorff, 2004; Rose et al., 2015) this analysis (1) provided new information from MHMI state legislation by exploring new intellectual territory, (2) described the characteristics of MHMI state legislation and summarized the features of its textual content, and (3) examined the legislative outcomes for any patterns or predictors. For example, Q1a was exploratory and descriptive, as the language of state MHMI legislation had yet to be examined for stigma in prior studies. Q1b was previously studied by Corrigan et al. (2005), but this study examined an entirely different time period encompassing multiple years; thus, Q1b was also exploratory and descriptive. Finally, the entirety of Q2 used elements of all three, as its purpose was to explore and describe the patterns of state MHMI legislation in order to predict legislative outcomes.

Content

Two types of content were analyzed throughout the analysis: the overt and countable content in the text (manifest content) as well as meanings interpreted from the implications of the text (latent content) (Drisko & Maschi, 2015; Rose et al., 2015). The design was deductive in that it sought to test theoretical ideas as well as used a priori coding methods through a codebook that was completed prior to data collection (Drisko & Maschi, 2015) (Appendix A). For example, to

answer Q1, latent meanings were interpreted from the manifest content of the legislative proposals, as to my knowledge, there is currently no method to measure structural stigma in textual data. To answer Q1a, Link and Phelan's (2001) conceptualization of stigma was used to interpret and codify stigmatic meanings in the language of the bills. For Q1b, Corrigan et al.'s (2005) conceptualization of structural stigma was used to interpret and codify the bill's language for potentially restricting structural consequences that would negatively affect people with MHMI conditions. Conversely, rather than interpreting latent meanings, Q2a/b were answered simply by codifying the overt and countable characteristics of the proposals and their sponsors, such as current status, gender, and political party (Q2c used findings from previous questions). The operationalization of the variables and the analysis procedures will be further described below.

Strengths and Limitations

Flexibility was the biggest strength of this design, in that it was used in combination to explore, describe, and predict (Gaur & Kumar, 2018; Rose et al., 2015). Other methodological advantages of the design included the use of naturally occurring data, the unobtrusiveness to human participants (Gaur & Kumar, 2018; Krippendorff, 2004; Rose et al., 2015), limited participant bias (e.g., recall bias) (Drisko & Maschi, 2015; Gaur & Kumar, 2018; Insch et al., 1997), and the ability to cope with large amounts of unstructured data (Gaur & Kumar, 2018; Krippendorff, 2004; Rose et al., 2015). However, the design utilized a single coder to conduct the analysis, which introduced limitations in the trustworthiness of the findings due to the potential for inconsistency in the application of the codebook (poor intracoder reliability) or researcher bias inherent in the nature of the subject matter (Maier, 2017; Rose et al., 2015). Study limitations are discussed further in Chapter 5.

Guided by the literature (Lincoln & Guba, 1985), I addressed potential issues of bias and trustworthiness by increasing confirmability and dependability during the coding process. According to the authors, confirmability concerns the aspect of neutrality, while dependability concerns the aspect of consistency. The interpretation of texts should be grounded in the data, rather than based on my own viewpoints. Thus, I transparently described all coding steps from the start of data analysis in a research journal, including coding decisions and their rationalizations, logistical decisions involving study procedures, and reflections in terms of values and interests, in order to explain any ambiguity regarding subjective decisions. Ultimately, I will report on this process in any written works, making sure to include how my preconceptions, beliefs, and values due to my time as a MHMI lobbyist may have come into play during the research process.

Design Summary

In sum, the current study was a QCA that was deductive in design. The research questions were exploratory, descriptive, and predictive in nature, depending on the question. The study assessed and codified the manifest and latent content of qualitative, textual data and produced quantitative frequencies that were examined using uni- bi- and multivariate statistical analyses.

Data Collection

Dataset

There are four main stages in the methodology of a CA: data collection, coding, analysis, and interpretation of coded content (Weber, 1990). Currently, there is no comprehensive dataset of MHMI bills introduced at the state (or federal) levels, so the first step in data collection was to create one. Each state has its own legislative systems website that enables individuals or groups to track legislation, and most are equipped with databases that allow intrastate searches by topic

or time period, but the websites are independently operated and do not provide interstate tracking. Further, using 50 different websites for 50 independent searches could produce different results, even with consistent search terms; legislative tracking systems have different search function algorithms that could produce an incomplete dataset. Thus, rather than searching each state's legislative systems database separately, the dataset was formed using BillTrack50, an innovative online database that allows users to identify and track bills from all 50 states simultaneously, including their sponsors and outcomes (LegiScan, 2019). Users can search by state, bill topic, status, etc., from 2011- present. Typically, the site charges for access to all its features, but special permission was obtained from the owner for this dissertation, and she assisted in data collection. BillTrack50 saved time and increased the consistency of searches, as using a single site meant using a single search algorithm.

Search Criteria

The dataset was created using inclusion criteria related to topic, time period, and level of government. First, three search terms were used—piloted by Corrigan et al. (2005)—that conceptually encompassed MHMI: "mental health," "mental illness," and "psychiatry." Second, the dataset included bills that were introduced between January 2017- October 2019. Kingdon (1995) suggests that policy windows, or opportunities for advocates or policymakers to push their agendas, may open during crises or changes in national moods, social problems, and/or political administrations. Thus, this study's time period was chosen in order to represent the new (and most current) Presidential administration by encompassing all full legislative sessions between his oath of office on January 20, 2017 to when data collection began (late October 2019). Third, the dataset only included bills that were introduced at the state level. The level of government was chosen because MHMI systems are largely shaped at the state level versus the

federal level. While the federal government is a major funding source and partners with the states to address mental health, states have significant power in making decisions about their systems. As a result, regulations and available services can look very different from state to state. Also, while state systems must meet certain federal minimum standards, they are free to make their own decisions on whether or not to expand and improve public MHMI services and access (MHA, 2019b). Finally, many legislative proposals involving MHMI topics, such as criminal justice, gun control, education, child welfare, foster care, etc., are introduced at the state level.

Dataset Collection Procedures

Typical BillTrack50 results produce useful tools for legislative tracking, such as links to the bill PDFs, the names of legislators, etc., but the current study required additional variables. Thus, in collaboration with the owner, additional study variables were added into the code of the search function algorithm prior to the search (i.e., gender, political party, chamber, current bill status, state of introduction, and majority/minority status). Next, the time period and search terms were entered into the search parameters, and the search was completed. According to an initial search, over 17,000 MHMI bills across all 50 states were introduced from January 2017-October 2019. After duplicate bills appearing multiple times in the search results were deleted, the final search yielded 15,072 bills. All results were converted to an excel sheet for exporting. Because the file was too large to download, the results were broken down into four separate excel sheets, downloaded separately, and combined to create the study's dataset.

Sampling

Sample Size

After creating the dataset, the study's sample was formulated. While there are no established criteria in CA for the size of a unit of analysis (i.e., a word, sentence, or entire bill) or the number

of units to study (Bengtsson, 2016), the amount of legislative proposals needed in the sample was determined by using a combination of past literature and statistical sampling theory. Krippendorf (2004, p. 122) provides a table (Figure 2 below) listing the desired level of significance (y-axis) as well as the probability of least likely units (PLLUs) when the units of text that would make a difference in answering the research question are rare (x-axis). For structural stigma, the PLLUs were determined by examining the results of Corrigan et al.'s 2005 study. The authors found that roughly 3% of bills contracted liberties, 11% contracted protections from discrimination, 4% contracted privacy rights, and 4% contracted resources. Ultimately, an overall average of 6% of state mental illness bills were structurally stigmatic in the year 2002. If the desired level of significance is $p < .05$, then the sample would need to be at least 150 bills to answer the research questions with confidence. To achieve a robust sample size, the current study rounded up and analyzed 200 bills.

Figure 3

Sample Size: Least Likely Units and Significance Level

		Probability of Least Likely Units in the Population				
		.1	.01	.001	.0001	.00001
Desired Level of Significance	.5	7	69	693	6,931	69,307
	.2	16	161	1,609	16,094	160,942
	.1	22	230	2,302	23,025	230,256
	.05	29	299	2,995	29,955	299,563
	.02	37	390	3,911	39,118	391,198
	.01	44	459	4,603	46,049	460,512
	.005	51	528	5,296	52,980	529,823
	.002	59	619	6,212	62,143	612,453
	.001	66	689	6,905	60,074	690,767

Note. All sampling units equally informative (Krippendorf, 2004, p. 122).

Sampling Procedures

CA sampling is often multistage and typically consists of identifying a sampling frame of interest and then selecting a sample from within that frame, often via probability sampling techniques (Drisko & Maschi, 2015). Probability sampling requires random sampling—each bill has an equal chance of being selected—and allows for the use of inferential statistics to make generalizations (Drake & Jonson-Reid, 2008; Drisko & Maschi, 2015; Krippendorf, 2004).

This dissertation's sampling process is illustrated below in Figure 3 (p. 11). The study's sampling frame consisted of 15,072 state-level, MHMI bills introduced between January 2017-October 2019. To narrow the sampling frame and ensure equal representation of important variables (i.e., political party and current bill status), stratified random sampling (SRS) was conducted. SRS is a form of probability sampling that is used in place of simple random sampling due to a potentially heterogeneous frame. This study used proportionate SRS in particular, which divided the entire population into homogeneous groups and allowed for a more representative sample. Broadly, I followed the following steps adopted from the literature: (1) divide the sampling frame into strata based on shared characteristics (this step can be multistage), (2) take a random sample from each stratum separately, in a number that is proportional to the size of the stratum, and (3) pool the resulting subsets together to form the study's sample (Rubin & Babbie, 2005).

Step One. The sampling frame was stratified in two different stages, based on (1) political party majority of the state legislatures and (2) current bill status. First, because political party affects voting outcomes (e.g., Cox & Poole, 2002; Davidson, Oleszek, Lee, & Schickler, 2013; Snyder & Groseclose, 2000) and states are not divided equally across party lines, the sampling frame was divided into Republican (n=7,355) and Democratic (n=7,717) strata. Second, to ensure equal representation of the study's dependent variable (DV; bill's current status), all

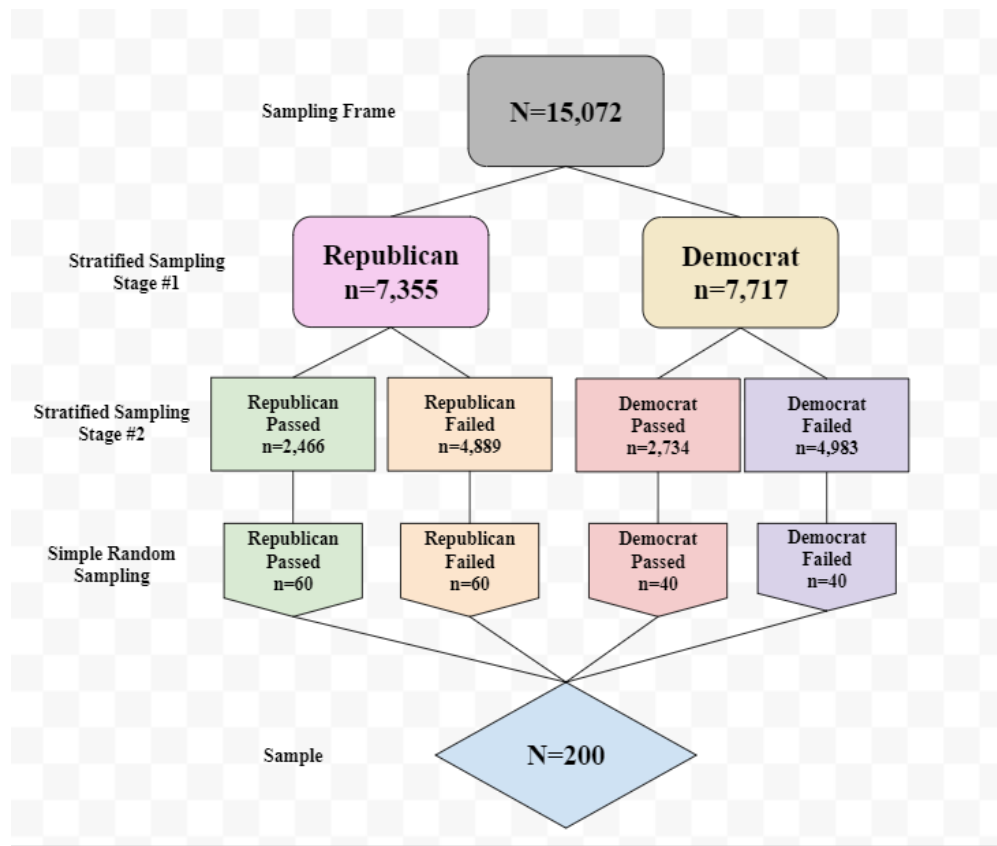
Republican and Democratic bills were divided into pass versus fail, for a total of four strata (Republican=2,466 passed, 4,889 failed; Democrat= 2,734 passed, 4,983 failed; $N=15,072$). Bills in each pool were given unique ID numbers to be used during the random selection process in step two.

Step Two. Next, simple random sampling was conducted from each of the four stratum to achieve (1) equal representation of the DV as well as (2) the proportional representation of political parties during the popular vote of the last presidential election. For instance, in 2016, 30 states voted red (Republican; 60%), while 20 states voted blue (Democrat; 40%; Politico, 2016). Given the sample size for this dissertation ($N=200$), the sample should then be divided into 120 Republican bills (60% of the sample size) and 80 Democratic bills (40% of the sample size) to achieve a proportionate and robust sample. Thus, bills were randomly selected from each of the four stratum until an equal number of passed versus failed bills were selected per stratum, proportional to the state vote (Republican=60 passed, 60 failed; Democrat= 40 passed, 40 failed). As all bills were uniquely numbered in each of the four stratum, a random number generator was used for this process to ensure random selection, and each stratum was completed separately. For example, the ‘Democrat- Failed’ pool was the first pool completed, and bills in this pool were numbered 1- 4,983. Random numbers were generated between 1- 4,983 until 40 bills that met the inclusion criteria were selected (those that did not were marked and removed). Upon completion of the ‘Democrat- Failed’ stratum, the ‘Democrat- Passed’ pool was started (Bill IDs: 4,984- 7,717). This process continued until all strata were completed.

Step Three. Finally, all four strata were pooled together to form the dissertation’s sample (Republican=60 passed, 60 failed, $n=120$; Democrat= 40 passed, 40 failed, $n=80$; $N=200$). Once again, this process is illustrated below in Figure 3.

Figure 4

Stratified Random Sampling Process



Operationalization of Variables

The variables measured for the current study examined the MHMI policy process related to the bills, sponsors, and institutions involved. For example, bill related variables referred to characteristics about the bills themselves; sponsor related variables were characteristics about the legislator introducing the bill; and finally, one institution related variable examined the chamber in which the bill was introduced. All variables are further operationalized below.

Bill Related Variables

Topic

MHMI legislative proposals were topically categorized in order to describe the current landscape of MHMI legislation in the states. This process was guided by categories operationalized in Purtle and Lewis's (2017) policy mapping study of trauma-informed legislative proposals that were introduced federally in the last few decades. The authors inductively coded—let the data dictate—the topic of relevant bills based on both the population targeted (e.g., foster youth) and the sector in which the bill was intended to be implemented (e.g., health care, gun control, education; Purtle & Lewis, 2017). This study did something similar by inductively coding every bill's topical area, only after considering a combination of each bill's target population and sector of implementation.

Typology

Bills were also categorized into types of policy instruments. In his content analysis of federally introduced, PTSD-related bills, Purtle (2014) utilized Howlett et al.'s (2003) policy instrument typology to describe how policies have been designed to address PTSD in the last few decades. Howlett and colleagues first recommended coding each policy as either a symbolic or material instrument. Symbolic instruments are designed to bring awareness to an issue, while material instruments are designed to bring actual change via altering resources or processes. Second, the authors recommended coding all material instruments as either substantive (altering funding or services) or procedural (altering processes or procedures). The current study followed the same process, and each bill was coded as only one of the following: symbolic (no=0, yes=1), material-substantive (no=0, yes=1), or material-procedural (no=0, yes=1).

Current Status

The bill's current status was the main DV of research question #2 and was coded as either (0) fail or (1) pass, an operationalization that is often used in studies examining policy outcomes

(e.g., Eyler et al., 2012). For the purposes of this study, pass was operationalized as passed by both houses and enacted into law by either the Governor's signature or his/her inaction (some states do not require a Governor's signature to be enacted). Fail was operationalized as all other bill designations or statuses, including if the bill was tabled before a vote.

Structural Stigma: Potential Effect

Certain factors at the structural level can serve to keep individuals with MI down, in, or away (Link & Phelan, 2014). For example, MHMI bills may have restricting consequences on people with MHMI conditions due to changes enacted, either directly or indirectly, by the new bill's implementation. Thus, the current study operationalized the construct of structural stigma in the potential effect of the bills by utilizing existing categories created by Corrigan et al. (2005), who examined MI structural stigma in state legislatures in 2002. In operationalizing structural stigma, the authors first conducted a focus group that included mental health advocacy groups with policy expertise in order to strengthen content validity. Participants were asked to provide and discuss current and past legislative examples that could be discriminatory toward individuals with MI. Analyses of the focus group transcript yielded the following three categories of bills that affect individuals with mental illness: (1) those that affect personal liberties (bills that expand or contract rights regarding physical liberties or seeking/refusing treatments), (2) those that affect protections against discrimination (bills that expand or contract protections regarding employment, housing, or other services), and (3) those that affect privacy (bills that expand or contract confidentiality or privacy rights; Corrigan et al., 2005). Through the piloting process, the authors added a fourth category examining whether the bill expanded or contracted resources or services, as funding bills represented the most common form of legislation in their study (Corrigan et al., 2005). Thus, the current study codified structural stigma present in the potential

effect of state MHMI legislation as one of the following five codes: (0) not structurally stigmatic in potential effect, (1) those that reduce personal liberties, (2) those that reduce protections against discrimination, (3) those that reduce privacy, and (4) those that reduce resources and services. The variable was then recoded (dummy coded) into exhaustive categories: structurally non-stigmatic in potential effect (0=0) or structurally stigmatic in potential effect (1-4=1).

Structural Stigma: Language

The current study operationalized the construct of structural stigma in the language of the bills by utilizing Link and Phelan's (2001) conceptualization to deductively code the five stigmatic elements of labeling, stereotyping, separating, status loss, and discrimination. Once again, the authors' conceptualization is contingent upon access to social, economic, and political powers that allow for the above elements to occur. As legislators were elected via the public to make budgetary and legislative decisions, they hold all three forms of power; thus, the conditions are right for each element of stigma to occur. The authors do not provide direct definitions of the five core elements in their 2001 article, so the current study used the following definitions from the literature:

1. Labeling- the bill uses MHMI-related labels that distinguish certain characteristics and have assigned social significance to them (Link et al., 2004). Examples:

- a. mentally ill, consumer, addicted, severely impaired, insane, incompetent, behaviorally disabled, etc.

2. Stereotyping- the bill links labeled differences to negative attributes (Link et al., 2004).

Examples via Hayward and Bright (1997):

. they are dangerous

- a. they are unpredictable and unable to follow social roles

- b. they are responsible for their conditions
 - c. their illness is chronic, difficult to treat, and difficult to recover from
- 3. Separating- the bill has language that implies a fundamental difference between those with MHMI conditions ("them") and those without ("us"; Link et al., 2004); **and/or**, the bill seeks to literally separate people with MHMI conditions from those seeking other forms of healthcare. Examples:
 - a. a person IS schizophrenic vs. HAS cancer
 - b. people with MHMI are placed in separate psychiatric facilities
- 4. Status loss- the bill's language has expectations, beliefs, or suggestions for people with mental illness to lose status (Link et al., 2004); **and/or**, there is a downward placement of a person in a status hierarchy (Link & Phelan, 2001).
- 5. Discrimination- the bill's language seeks to disadvantage people with mental illness (Link et al., 2004). Examples are loss of rights in the areas of:
 - a. owning a firearm, involuntary commitment, employment, housing, etc.

Latent stigmatic content that labeled, stereotyped, suggested separation/status loss, or discriminated against people with MHMI conditions were coded as such, using the research journal to document and explain coding decisions. The elements were mutually exclusive, yet sometimes occurred simultaneously. Each element was coded dichotomously, according to their absence or presence (no=0, yes=1), and were added together to make a determination of stigmatic language. In this study, the bill was considered stigmatic in language if three out of five elements were present, which is representative but less stringent than Link and Phelan's (2001) definition, where stigma only occurs if all five elements are present. Bills were then dummy

coded into exhaustive categories: structurally non-stigmatic in language (0-2=0) or structurally stigmatic in language (3-5=1).

Sponsor Related Variables

Demographics

The literature discusses gender differences in legislative behavior and policy preferences. Bratton & Haynie (1999) found that women have distinct policymaking foci and are more likely to sponsor bills on issues such as education or welfare policy. Further, there are gender differences in the literature on roll-call voting for regulatory and economic policies (Hogan, 2008), women's issue bills (Swers, 1998), and welfare policies (Poggione, 2004). Thus, the gender of the sponsor(s) of the bill was recorded and coded (female=0; male=1). Other variables can also affect legislator voting behavior, including race (Montgomery & Nyhan, 2017), parenting females (Washington, 2008), education level, and age (Rocca et al., 2008), but were beyond the scope of the current study, as they were too difficult to determine electronically. The addition of these variables is mentioned as a goal for future research in Chapter 5.

Political Party- Sponsor

As mentioned earlier, a legislator's political party influences their voting behavior. For example, party affiliation has been found to be significantly associated with voting behavior on social welfare issues (Barrett & Cook, 1991) and substance abuse issues, such as tobacco control (Cohen et al., 2002). Thus, the current study recorded the political party of the sponsor(s) of the bill at the time of introduction (0=Republican; 1=Democrat).

Political Party- Majority/Minority Status

Bill sponsors are members of political parties and those parties may either be in the majority or the minority of the chamber in which bills are introduced. Lawrence et al. (2006) found a

significant relationship between voting results and majority/minority status, most notably that legislative outcomes were most often on the majority party's side of the chamber median. Thus, sponsor membership in either the majority or minority party in the chamber (House/Senate) in which the bill was introduced was also recorded (0=Minority, 1=Majority).

Institution Related Variables

Chamber

The current study recorded the bill's chamber. Often, Houses of Representatives are considered 'lower' chambers in legislatures, while Senates are considered 'upper'. Thus, the current study coded chambers as either 0=Lower, 1=Upper.

Table 1 (p. 62) summarizes the study's coding scheme, including bill- institution- and sponsor-related variables, reflecting changes made after the pilot. Each variable is broken down by their item definitions and overall codes. The codes are also included in the study's codebook (Appendix A).

Data Analysis

Coding Procedures

Coding Scheme

Consistent with past literature (Duriau et al., 2007), the coding process consisted of two main components: (1) the development of a coding scheme, or rules for classifying coding units to categories based on past literature, and (2) the coding process itself. Guided by the process outlined in Rose et al. (2015), the current study first developed coding units based on the research questions and concepts to be examined; each variable was ultimately coded once for each bill and sponsor (bills were either symbolic or material, stigmatized in language or not, proposed by a male or female, etc.). Second, in collaboration with the owner of BillTrack50, a

coding scheme (Table 1) was developed and cataloged into a codebook (a manual specifying what to code and how to code it) that aided in systematic and replicable coding of the textual data (Appendix A). Third, the BillTrack50 dataset was exported into an excel coding form and expanded upon for further coding of the other independent variables (IVs; structural stigma, bill topic, etc.). Fourth, to identify problems in the coding scheme or the coder’s ability to apply it, the coding scheme was piloted using a randomly selected portion of the overall sampling frame (pilot study discussed in further detail below). Finally, once piloting issues were addressed, the coding scheme and codebook were finalized and coding began, including the ongoing maintenance of the research journal that consisted of logistical coding decisions as well as reflexive rationalizations.

Coding Procedures

Once 200 bills were identified, their PDFs were downloaded and stored in a google drive folder. Excel sheets were expanded upon, with each variable as a different column header. Figure 4 below illustrates some of the stigma variables.

Figure 5

Coding Form: Example of Study Variable Headers

Q	R	S	T	U	V	W	X	Y	Z	AA	
Labeling	Stereotyping	Separating	Status Loss	Discrimination	Structural Stigma-L	Reduces Liberties	Reduces Protections	Reduces Privacy	Reduces Funding	MHMI Structural	Symbo
0	0	1	1	1	1	0	1	0	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	1
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	0	1	1	1	0	1	0	0	1
0	1	1	0	1	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	1	0	0	1	0	0	0	1
0	1	0	0	1	0	0	0	0	0	0	0
1	1	1	1	0	1	0	0	0	0	0	0
1	1	1	0	0	1	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0	0	0

Using the codebook, sponsor-related variables were coded first (i.e., gender and political party). Bill PDFs were then opened, read, and coded for topic, typology, and structural stigma in their

language and potential effects. Each variable was coded in excel, and the research journal was updated after each bill. Explanations and reflections were recorded in the research journal regarding any latent content being considered, including typology and both structural stigma variables. After all 200 bills were coded, the results were exported from excel into SPSS 26 (IBM Corporation, 2019) for cleaning and analysis.

Pilot Study

The pilot study was conducted in December of 2019. The procedures above were followed with a sample of 20 bills (10% of the sample size), randomly selected from the overall sampling frame. Three main lessons were learned and added to the dissertation's coding procedures:

1. The sampling frame was created by searching entire bills for each of the three specified search terms. However, bills are often introduced simply to make a small change to a large existing law. For example, frequently during the pilot, the three search terms were not included in the part of the bill that was being changed (the new language), but were instead scattered somewhere else in the law. This meant that while the bill was rightfully flagged for the sampling frame, the piece of the bill being changed was often irrelevant to MHMI. Thus, as a new inclusion criterion, bills could only be included in the sample if the three search terms were in the new language, or piece of the bill being changed.

Note: This change did not affect bills that were entirely new, as the search terms were always a part of the new language.

2. During the pilot, it was determined the coding scheme for several variables needed to be expanded and/or changed. For example, bills were often sponsored by multiple legislators, with multiple genders, in multiple parties. To account for multiplicities, the current study changed the gender/political party variables to 'Majority Gender' and

‘Majority Political Party- Sponsor’. This alleviated the issue, but opened up the possibility for splits, which created a new category for both variables as well as for ‘Political Party- Majority/Minority Status’. In addition, other categories of codes came up during searches for ‘Political Party- Sponsor’, specifically the categories of ‘Nonpartisan’ (introduced in the state of Nebraska, which has a unicameral and nonpartisan legislature) and ‘Introduced by Committee’. Finally, in rare instances, information on legislators could not be found via BillTrack50, the state’s website, or the individual bill, because they were introduced by a committee or they were simply not listed. Thus, a category of ‘Missing’ was added for all three variables. As a result, the new codes for the ‘Majority Gender’ variable were 0=Female, 1=Male, 2=Split, 3=Committee, 4=Missing. The new codes for the ‘Majority Political Party- Sponsor’ variable were 0=Republican, 1=Democrat, 2=Split, 3=Committee, 4=Non-partisan, 5=Missing. Further, ‘Political Party- Majority/Minority Status’ was changed to 0=Minority, 1=Majority, 2=Split, 3=Missing.

3. When creating the coding scheme, it was undecided whether bills could be classified as multiple items per variable (e.g., both symbolic & material-substantive). During the pilot, it was discovered that bills typically fell cleanly into one category versus another on most variables, so it was decided that each variable was to be classified as one item, rather than multiple items. The exception to this rule was structural stigma- potential effect, as all types were captured per bill, in order to document all instances of stigma. This decision only affected frequency distributions and did not affect bi- or multivariate analyses in any way, as only one of the four subtypes was needed to be coded as structurally stigmatic in potential effect overall.

Table 1

Operationalization of Study Variables

Item Definitions and Variable Codes	
Bill related variables	
<i>Italicized definition=inductive</i>	
Bill Topic	<i>Combination of the population in which the bill is intended to affect & the sector where the bill will be implemented</i>
Typology	<p><u>Item definitions:</u></p> <ol style="list-style-type: none"> 1. Symbolic- instruments that are designed to bring awareness to an issue 2. Material-substantive- instruments are designed to bring change via altering resources 3. Material-procedural- instruments are designed to bring change via altering processes <p><u>Items independently coded as:</u></p> <ol style="list-style-type: none"> 0. No 1. Yes
Current Status	<ol style="list-style-type: none"> 0. Fail is defined as all other bill designations or statuses 1. Pass is defined as passed both houses and signed into law by the Governor
Structural Stigma: Potential Effect	<p><u>Item definitions:</u></p> <ol style="list-style-type: none"> 1. Restricts liberties- bills that contract rights regarding physical liberties or seeking/refusing treatments 2. Restricts protections against discrimination- bills that contract protections against discrimination regarding employment, housing, or other services 3. Restricts privacy- bills that contract confidentiality or privacy rights 4. Restricts resources- bills that contract resources or services <p><u>Items independently coded as:</u></p> <ol style="list-style-type: none"> 0. No 1. Yes <p><u>Variable coded as:</u></p> <ol style="list-style-type: none"> 0. Non-stigmatic in potential effect (all 4 items coded as 0) 1. Stigmatic in potential effect (any of the 4 items coded as 1)
Structural Stigma: Language	<p><u>Item definitions:</u></p> <ol style="list-style-type: none"> 1. Labeling- the bill uses MHMI-related labels that distinguish certain characteristics and have assigned social significance to them (Link, Yang, Phelan, & Collins, 2004). Examples: mentally ill, any diagnostic label, mental disorder, etc. 2. Stereotyping- the bill links labeled differences to negative attributes (Link et al., 2004); Examples: (1) they are dangerous; (2) they are unpredictable and unable to follow social roles; (3) they are responsible for their conditions; and (4) their illness is chronic, difficult to treat, and difficult to recover from (Hayward & Bright, 1997). 3. Separating- the bill has language that implies a fundamental difference between those with MHMI conditions ("them") and those without ("us"; Link et al., 2004), examples: a person IS schizophrenic vs. HAS cancer; AND/OR the bill seeks to literally separate people with MHMI conditions from those seeking other forms of healthcare. Examples: separate psychiatric facilities. 4. Status loss- the bill's language has expectations, beliefs, or suggestions for people with mental illness to lose status (Link et al., 2004); downward placement of a person in a status hierarchy (Link & Phelan, 2001). 5. Discrimination- the bill's language seeks to disadvantage people with mental illness (Link et al., 2004). <p><u>Items independently coded as:</u></p> <ol style="list-style-type: none"> 0. No 1. Yes <p><u>Variable coded as:</u></p> <ol style="list-style-type: none"> 0. Non-stigmatic in language (2 or less items coded as 1) 1. Stigmatic in language (3 or more items coded as 1)
Sponsor related variables	
Majority Gender	<ol style="list-style-type: none"> 0. Female 1. Male 2. Split 3. Committee 4. Missing

Majority Political Party	0. Republican
	1. Democrat
	2. Split
	3. Committee
	4. Non-partisan
	5. Missing
Party Status	0. Minority
	1. Majority
	2. Split
	3. Missing
Institution related variable	
Chamber	0. Lower (House of Representatives)
	1. Upper (Senate)

Statistical Analyses

Final analysis of the data in a quantitative CA involved application of quantitative statistical techniques. Rose et al. (2015) suggest conducting descriptive statistics using frequency counts as well as inferential statistics to answer any relevant research questions. Thus, the study utilized descriptive statistics to summarize and organize the coded data, while inferential statistics were used to determine predictors of bill status and relationships between categorical variables.

Data Cleaning

Before any statistical analyses were run, the dataset was downloaded from excel to SPSS 26 (IBM Corporation, 2019) and cleaned. Cleaning procedures first included finding and recoding missing data. Missing data upon first importation into SPSS were rare and typically only happened when bills were introduced by committees instead of sponsors (missing variables=legislator gender, party, etc.), or due to clerical errors by the legislature of introduction. Missing data were imported as blank and were recoded to missing (-999); they were not included in subsequent analyses. Second, variable values (e.g., 0=Fail, 1=Pass) and labels (e.g., Bill Status) were added and fixed using rename syntax. Third, the gender and political party variables, which were converted to majority variables after the pilot, were converted to binary variables using recode syntax in order to remove rare or irrelevant categories, such as ‘split’ or ‘nonpartisan’, from analyses. For example, the ‘Majority Gender’

variable was recoded from '0=Female, 1=Male, 2=Split, 3=Missing' into '0=Female, 1=Male, 2-3=-999', and the 'Majority Political Party- Sponsor' variable was recoded from '0=Republican, 1=Democrat, 2=Independent, 3=Split, 4=Committee, 5=Non-partisan, 6=Missing' into '0=Republican, 1=Democrat, 2-6=-999'. The political party recode was consistent with past research, especially given the historical dominance of the two-party system in America. Data recoded as -999 were considered missing and were excluded listwise from subsequent analyses. This did not affect the power of the analyses, as the sample size remained above 150 (N=167 in the regression model).

Univariate Statistics

Univariate analyses of all variables were conducted to describe the sample and to answer research question #1, which explored the presence and nature of structural stigma in the introduced bills. As appropriate, preliminary descriptive analyses included frequency distributions or measures of dispersion or central tendency, depending on the level of measurement of each variable.

Bivariate Statistics

The chi-square test (χ^2) of independence was used to examine the relationships between categorical variables in both research questions. According to Tabachnick and Fidell (2013), in a chi-square analysis, observed frequencies are tested against expected frequencies, generated by the null hypothesis. If the frequencies are similar, then the χ^2 value will be small, and the null will be supported. Conversely, if they are sufficiently different, then the χ^2 value will be large, the null will be rejected, and the results will be significant (Tabachnick & Fidell, 2013). This dissertation used chi-square to determine if associations existed between categorical IVs (i.e., typology, gender, political party-sponsor, chamber majority/minority, chamber upper/lower, and

structural stigma potential effect/language) and dichotomous DVs (e.g., current status of the bill). While the chi-square statistic determines the significance of associations between variables, it does not provide the direction of relationships; thus, the observed versus expected counts in the crosstabulation tables were also examined to determine the nature of any significant relationships.

Multivariate Statistics

Logistic regression was used to determine if one or more of the IVs predicted any DVs in both research questions (Tabachnick & Fidell, 2013). Logistic regression can be binary or multinomial, depending on the dependent variable. As current status and both structural stigma variables were dichotomous and coded as binary, binary logistic regression was used.

Assumptions. Logistic regression is an appropriate analysis to run if several assumptions are met: (1) the DV is binary, (2) observations are not from repeated measurements, (3) there is limited multicollinearity among the IVs (the IVs are not linear functions of one another), and, due to its use of maximum-likelihood estimation, (4) the sample size is sufficiently large (Warner, 2020). As previously discussed, this dissertation used all binary DVs and was cross-sectional, without repeated measurements or duplicates. Multicollinearity was assessed by running a series of linear regressions with the IVs to be used in the logistic regression model and examining the variance inflation factor (VIF) scores for each IV. The VIF score gives the researcher an indicator of any problematic linear relationships between IVs by displaying the ratio of ‘variance in a model with multiple predictors’ to ‘variance in a model with one predictor’ (Field, 2013). The range of problematic VIF scores varies, depending on the author: some suggest scores greater than 5 indicate problems with multicollinearity (Hair et al., 2010), while others suggest cutoffs of greater than 10 (Bowerman & O’Connell, 1990; Myers, 1990).

However, in this dissertation, all scores were two and below, indicating low multicollinearity (Warner, 2020). Finally, in terms of sufficient sample size, Hosmer et al. (2013) suggest greater than 20 cases per IV included in the model. All IVs included in each of the regression models far exceeded 20 cases, confirming a sufficient sample size (Hosmer et al., 2013).

Model. Of key importance in a logistic regression model is choosing the right IVs to be in the model (Ranganathan et al., 2017). According to Williams et al. (2008), there are several ways to choose, including forward and backward selections. In forward selection, the chi-square score for each IV is examined for significance at a certain p value. Each significant IV is added to the previously empty model and is not removed once added. The process is repeated until all significant IVs are in the model. Conversely, in backward elimination, all relevant IVs based on past theory and research are added into the model to start. The model is run, and the results of the Wald test (chi-square statistic and p value) are examined. The least significant IV is removed from the model each time, and remains excluded once removed. The process is repeated until only significant IVs at a certain p value remain in the model (Williams et al., 2008). The current study used the more conventional forward selection technique (Ranganathan et al., 2017) and examined bivariate analysis results (chi-square, $p < .05$) to identify potential predictor variables for the models. Notably, the authors suggest a more liberal cutoff for significance ($p < .10$), as the purpose of forward selection is to identify predictors for a regression model rather than test hypotheses; nevertheless, the same IVs were significant in the models run, regardless of the cutoff p values. Lastly, as a final step, backward selection was performed to confirm the inclusion of the IVs; both techniques produced identical results, supporting the choices for the models.

The models could be evaluated using several statistics. The Nagelkerke R^2 is a coefficient of determination indicating a model's fit (the proportion of variance explained), and values closer to one suggests a better fit (Nagelkerke, 1991). However, according to Peng et al. (2002), when reporting the goodness-of-fit for the model in logistic regression, it is more useful to examine the Hosmer-Lemeshow goodness-of-fit statistic rather than the Nagelkerke, as the latter is typically used for linear regression. Dattalo (2013) agrees, recommending the Hosmer-Lemeshow test particularly for logistic regression models with a binary DV. For the current study, all models (except one discussed later) had goodness-of-fit statistics with p values greater than 0.05, indicating acceptable model fits (Dattalo, 2013).

After the models were determined to be a good fit, the binary logistic regression outputs were interpreted, including several different columns. Beta coefficients (B) represent the predicted change in log odds for every one-unit increase on a predictor. Positive betas in a model indicate that increasing scores on a predictor variable (e.g., political party- democrat [1]) are associated with an increasing likelihood of membership in an outcome variable's target group (e.g., DV=1; current bill status=pass [1]). Conversely, negative coefficients in a model indicate that increasing scores on a predictor variable (e.g., political party- democrat [1]) are associated with a decreasing likelihood of membership in an outcome variable's target group (e.g., DV=1; current bill status=pass [1]). While beta coefficients are useful in interpreting regression results, $\text{Exp}(B)$, or the exponentiation of beta, is most often reported in studies using binary logistic regression. $\text{Exp}(B)$ is a change in odds of being in one of the categories of the DV when the value of an IV increases by one unit. Odds ratios greater than one correspond with positive beta coefficients and represent the increase in odds of target group membership (DV=1) with a one-unit increase in an IV. Conversely, odds ratios lower than one correspond with negative betas and represent the

decrease in odds of target group membership (DV=1) with a one-unit increase in an IV (Field, 2013). Finally, the Wald test is testing the null hypothesis (that each IV could be dropped from the model without affecting the results) and produces a chi-square statistic with a corresponding p value for each IV. If the p value is insignificant and the chi-square statistic is low for a particular IV, that variable is not assisting in the prediction of the DV and could theoretically be dropped from the model without harming the fit of that model. Odds ratios, confidence intervals, and Wald test statistics are provided in Chapter 4. Below, Table 2 summarizes the statistical analyses to correspond with each research question.

Table 2

Statistical Analyses

Q1: What is the nature of structural stigma in state MHMI bills?			
Variables	Descriptive or Inferential	Uni-, Bi-, or Multivariate	Statistical Tests
Structural Stigma: Potential Effect	D	U	Frequency Distribution
Structural Stigma: Language	D	U	Frequency Distribution
IVs: ALL DV: Structural stigma variables	I	B	Chi Square
IVs: ALL DV: Structural stigma variables	I	M	Binary Logistic Regression
Q2: What is the relationship between legislative factors and state MHMI policy outcomes?			
Variables	Descriptive or Inferential	Uni-, Bi-, or Multivariate	Statistical Tests
IVs: ALL DV: Voting outcomes	I	B	Chi Square
IVs: ALL DV: Voting outcomes	I	M	Binary Logistic Regression

Ethical Considerations

The Institutional Review Board (IRB) at Virginia Commonwealth University was not involved in this dissertation, as the study did not meet the definition of human subjects research and in turn, was not subject to a full IRB review.

Chapter 4: Results

This chapter presents the results of the current study that seeks to address two main research questions:

1. What is the nature of structural stigma in state MHMI legislative proposals?
2. How do sponsor, institutional, or bill-related factors influence state MHMI legislative outcomes?

The chapter begins with statistical descriptions of the states, bills, sponsors, and institutions represented in the sample. Next, results related to research question #1 are presented, including frequencies of structural stigma present in state MHMI legislation. Finally, bi- and multivariate results related to research question #2 are presented, to include factors that affect or predict voting outcomes. Bivariate results are presented first, as they were used to inform the study's regression model. Multivariate results conclude the chapter, illustrating details of the model as well as corresponding binary logistic regression results.

Descriptive Characteristics

Frequency Distribution of the Sample

The final sample consisted of 200 MHMI legislative proposals, introduced across the country from January 2017- October 2019. The sampling process consisted of multistage, stratified random sampling based on political party and current bill status: (1) all MHMI bills were split into two large strata based on state popular vote results during the 2016 presidential election (Republican/Democrat); (2) bills in each stratum were stratified a second time by current status (Fail/Pass); and (3) using a random number generator, bill PDFs were randomly selected from each of the four stratum until proportional to the state popular votes during the 2016 Presidential

Election (Republican/Fail [n=60]; Republican/Pass [n=60]; Democrat/Fail [n=40]; Democrat/Pass [n=40]).

Table 3 displays the results of the sampling process, including frequency distributions of the bills and states, for purposes of organization, summation, and description. The sample included 48 states and the District of Columbia, while two states were randomly excluded (i.e., Delaware and Georgia). 59% (n=29) of the states voted Republican in their popular votes during the 2016 presidential election, while 41% (n=20; 19 states, 1 district) voted Democrat. The average amount of bills per state was roughly four ($\mu=4.08$, median/mode=4), and states with the most bills in the sample included Texas (22), Indiana (11), New York (11), and Missouri (9).

Table 3

Distribution of the States and Bills

State ^a	Bill Status N (F, P) ^b	Popular Vote ^{cd}	State ^a	Bill Status N (F, P) ^b	Popular Vote ^{cd}
Alabama (AL)	1 (1, 0)	R	Nebraska (NE)	1 (0, 1)	R
Alaska (AK)	1 (1, 0)	R	Nevada (NV)	2 (1, 1)	D
Arkansas (AR)	3 (2, 1)	R	New Hampshire (NH)	4 (1, 3)	D
Arizona (AZ)	4 (2, 2)	R	New Jersey (NJ)	2 (0, 2)	D
California (CA)	5 (0, 5)	D	New Mexico (NM)	2 (1, 1)	D
Colorado (CO)	5 (1, 4)	D	New York (NY)	11 (11, 0)	D
Connecticut (CT)	1 (0, 1)	D	North Carolina (NC)	2 (1, 0)	R
District of Columbia (DC)	2 (0, 2)	D	North Dakota (ND)	1 (0, 1)	R
Florida (FL)	8 (6, 2)	R	Ohio (OH)	4 (1, 3)	R
Hawaii (HI)	4 (3, 1)	D	Oklahoma (OK)	3 (0, 3)	R
Idaho (ID)	2 (2, 0)	R	Oregon (OR)	5 (2, 3)	D
Illinois (IL)	6 (1, 5)	D	Pennsylvania (PA)	4 (1, 3)	R
Indiana (IN)	11 (2, 9)	R	Rhode Island (RI)	3 (2, 1)	D
Iowa (IA)	6 (2, 4)	R	South Carolina (SC)	4 (2, 2)	R
Kansas (KS)	4 (1, 3)	R	South Dakota (SD)	2 (1, 1)	R

Kentucky (KY)	5 (3, 2)	R	Tennessee (TN)	2 (0, 2)	R
Louisiana (LA)	5 (2, 3)	R	Texas (TX)	22 (14, 8)	R
Maine (ME)	1 (0, 1)	D	Utah (UT)	5 (2, 3)	R
Maryland (MD)	4 (2, 2)	D	Vermont (VT)	3 (1, 2)	D
Massachusetts (MA)	3 (3, 0)	D	Virginia (VA)	4 (3, 1)	D
Michigan (MI)	4 (1, 3)	R	Washington (WA)	5 (1, 4)	D
Minnesota (MN)	8 (7, 1)	D	West Virginia (WV)	2 (2, 0)	R
Mississippi (MS)	1 (1, 0)	R	Wisconsin (WI)	2 (1, 1)	R
Missouri (MO)	9 (8, 1)	R	Wyoming (WY)	1 (0, 1)	R
Montana (MT)	1 (1, 0)	R	Totals	200 (100, 100)	R=29 D=20
				R=120, D=80	

Note. ^a N=48 States, 1 District. ^b F=Fail, P=Pass. ^c 2016 Presidential Election Results.

^d R=Republican, D=Democrat.

Frequency Distributions of the Variables

Bill Topic

The topics of the bills varied widely, but some common themes arose related to their target populations and systems of implementation. First, legislative proposals contained language that targeted specific populations in society, such as children and families; prenatal or postpartum women; Veterans; inmates; people with disabilities, SUD, or MHMI conditions; teachers and educators; foster youth; and survivors of domestic violence or sexual assault. Second, any changes called for in the language would need to be implemented in certain systems of society, including foster care; welfare; public schools; higher education; criminal, juvenile, and restorative justice; hospitals; law enforcement; coordinated care; and Medicaid or other types of insurance. Table 4 further illustrates the breadth of bill topics, organized by state of introduction.

Table 4*Distribution of Bill Topics*

State	Bill Topic	State	Bill Topic
Alabama (AL)	CIT Training	Nebraska (NE)	Criminal Justice
Alaska (AK)	Restorative Justice	Nevada (NV)	Criminal Justice
Arkansas (AR)	Involuntary Commitment	New Hampshire (NH)	Juvenile Justice
	Guardianship		Conversion Therapy
Arizona (AZ)	Visitation	New Jersey (NJ)	Primary Care
	Public Schools		Veterans
	Firearms		Veterans
	Residential Facilities		Education
California (CA)	MHMI Beds	New Mexico (NM)	Foster Youth
	MHMI Services (Treatment, Oversight, Interpretation)		Public Schools
	Youth Development Records		Children's Medicaid
Colorado (CO)	Inpatient SUD	New York (NY)	Criminal Justice
	Tobacco Tax		Autism
	Animal Assistance		Mandatory Reporting
	Podiatry		Restorative Justice
	Foster Youth		Developmental Disabilities
Connecticut (CT)	Interpretation Services	North Carolina (NC)	Conversion Therapy
			Public Schools (MH)
District of Columbia (DC)	Records	North Dakota (ND)	Inmate Health
	Criminal Justice		MHMI Providers
Florida (FL)	Services (MHMI, SUD, Telehealth)	Ohio (OH)	SUD
	Public Schools		MHMI Providers
	Juvenile Justice		Veterans
	Workers Compensation		Public Schools (MH)
Hawaii (HI)	Firefighter MH	Oklahoma (OK)	Children's MH
	Homelessness		Legal MHMI Training
	MHMI Services		Juvenile Justice
Idaho (ID)	Restitution	Oregon (OR)	MHMI Services
	Medicaid		School Safety
Illinois (IL)	Child Welfare	Pennsylvania (PA)	Art Therapy
	SUD		Veterans
	Firearms		Support Specialists
	Children and Families		TANF
	Data and Records		Licensing
	Maternal MH		Sexual Assault (Predators, Victims)
	SUD Offense		
Expungement			
Indiana (IN)	Public Schools (MH, Teacher Weapons Training)	Rhode Island (RI)	Child Advocacy
	Juvenile Justice		MHMI & SUD Insurance
	Insurance		
	Records		
Iowa (IA)	Domestic Violence MHMI Services	South Carolina (SC)	Workers Compensation
	Coordinated Care		Paid Sick Leave
	Liability		Veterans
	Guardianship		Providers
Kansas (KS)	Workforce Development	South Dakota (SD)	Providers
	MHMI Providers		Licensing
	Restorative Justice		
Kentucky (KY)	Licensing	Tennessee (TN)	Juvenile Justice
	MHMI Loan Assistance		Threat Assessment
	MHMI Outpatient		
	Opiate Tax		
	Animal Assistance		

Louisiana (LA)	Opiate Training School Terrorism Suicide Prevention Evidence-Based Programs	Texas (TX)	Maternal MH Public Schools (MH, Suicide Prevention, IEPs) Criminal Justice Records Peace Officers Death Penalty Jail Diversion First Responders Education Telehealth MHMI & SUD Services Veterans Licensing Coordinated Care Data Insurance Juvenile Justice Public Schools (MH)
Maine (ME)	Protective Custody	Utah (UT)	MHMI & SUD Services Jail Diversion Parentage Proceedings
Maryland (MD)	Restorative Justice Medication Adherence Maternal MH Child Advocacy Autism	Vermont (VT)	COPN Providers Police Training Records Health Security Children & Families Coordinated Care (Higher Edu)
Massachusetts (MA)	Criminal Justice MHMI Bullying Records	Virginia (VA)	
Michigan (MI)	Involuntary Commitment Guardianship MHMI Outpatient Opiates Homelessness Education	Washington (WA)	
Minnesota (MN)	Peace Officers MHMI Providers Veterans Trauma Beds	West Virginia (WV)	Providers Licensing
Mississippi (MS)	Public Schools (MH) Pregnant Offenders Licensing	Wisconsin (WI)	Conversion Therapy Public Schools (MH)
Missouri (MO)	School Safety Animal Assistance Death Penalty MHMI (Higher Edu) Emergency Services	Wyoming (WY)	Licensing
Montana (MT)	Coordinated Care (Communities & Schools)		

Independent Variables

Based on a series of factors that influenced legislator voting behavior in past research and theory, the independent variables of the study were characteristics of the sponsors, institutions, and MHMI bills present in the sample. Table 5 presents the distribution of independent variables in each of these three categories. The legislator sponsors that introduced the bills identified as 63% male (n=125), 48% democrat (n=95), 58% in the majority party of the chamber of the bill's introduction (n=115), and 57% in their state's House of Representatives (n=114). The bills were

92% material (n=183) versus 8% symbolic (n=17), in that they sought to create change rather than simply bringing awareness to an issue. Further, the bills were 61% material-procedural (n=122) versus 31% material-substantive (n=61), in that they sought to create change through amending procedures or processes rather than through adding additional resources or funding.

Table 5

Distribution of Demographic Independent Variables (N=200)

Independent Variable	N (%)
Legislator Demographics	
Majority Gender	
Female	39 (19.5)
Male	125 (62.5)
Split	17 (8.5)
Introduced by Committee	17 (8.5)
Missing	2 (1.0)
Majority Political Party	
Republican	72 (36.0)
Democrat	95 (47.5)
Split	13 (6.5)
Introduced by Committee	17 (8.5)
Non-partisan (Unicameral)	1 (0.5)
Missing	2 (1.0)
Political Party- Maj/Min Status	
Minority	52 (26.0)
Majority	115 (57.5)
Split	13 (6.5)
Missing	20 (10.0)
Institution Characteristics	
Chamber	
Lower- House	114 (57.0)
Upper- Senate	86 (43.0)
Bill Characteristics	
Typology	
Symbolic	17 (8.5)
Material- Procedural	122 (61.0)
Material- Substantive	61 (30.5)

Research Question #1: *What is the nature of structural stigma in state MHMI legislative proposals?*

The direct or indirect effects of bills can structurally stigmatize people with MHMI conditions by restricting them in some way. Further, bills can structurally stigmatize in their language through labeling, separating, stereotyping, reducing in status, or discriminating against people with MHMI conditions. Research question #1 addressed a gap in the literature by exploring and examining the nature of structural stigma present in the language and potential effect of MHMI legislative proposals, including any legislative factors that may affect or predict their introduction.

Univariate Results

The structural stigma variables were operationalized using a combination of past literature and theory. Structural stigma in the potential effect of the bills was operationalized using four categories that reflect the restrictive consequences of past MHMI legislation (Corrigan et al., 2005). Structural stigma in the language of the bills was operationalized using five categories that represent Link and Phelan's (2001) in-depth and widely utilized definition of stigma.

Table 6 provides univariate, frequency distributions of both structural stigma variables. The results indicate that overall, MHMI bills were 18% (n=36) structurally stigmatic in potential effect and 19% (n=38) structurally stigmatic in language. Regarding, 'structural stigma- potential effect', 12% (n=24) of bills restricted liberties, 9% (n=18) restricted protections against discrimination, 4% (n=8) restricted privacy, and 0.5% (n=1) restricted resources, for an overall μ of 6.38. In terms of the 'structural stigma- language' variable, 25% (n=50) of bills illustrated separation, 23% (n=45) stereotyped, 15% (n=29) reduced some form of status, 13% (n=25) illustrated discrimination, and 10% (n=20) labeled people with MHMI conditions.

Table 6*The Presence of Structural Stigma in State MHMI Legislative Proposals*

Independent Variable	N (%)
Structural Stigma- Effect	
Restricted Liberties	24 (12.0)
Restricted Protections Against Discrimination	18 (9.0)
Restricted Privacy	8 (4.0)
Restricted Resources	1 (0.5)
Structurally Stigmatic- Potential Effect ^a	36 (18.0)
Non-structurally Stigmatic- Potential Effect	164 (82.0)
Total	200 (100.0)
Structural Stigma- Language	
Labeling	20 (10.0)
Stereotyping	45 (22.5)
Separating	50 (25.0)
Status Loss	29 (14.5)
Discrimination	25 (12.5)
Structurally Stigmatic- Language ^b	38 (19.0)
Non-structurally Stigmatic- Language	162 (81.0)
Total	200 (100.0)

Note. ^a Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in one or multiple categories, it was coded as structurally stigmatic in potential effect. ^b Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in three out of five categories, it was coded as structurally stigmatic in language.

Legislative Examples

Table 7 (p.80) presents examples of both variables from the legislative sample. Introduced bills demonstrated ‘structural stigma- potential effect’ in the following ways:

1. Restricted liberties- forced certain individuals to receive MHMI treatment, participate in certain MHMI programs, or sit for MHMI evaluations; restricted the rights of wards and granted additional power to guardians; added restrictions on the possession or purchase of firearms; broadened the criteria for involuntary commitment and temporary detention

orders (TDOs); forced medication adherence; and, empowered law enforcement to force transportation on an individual if they missed their required evaluation.

2. Restricted protections against discrimination- lengthened the period of time required before individuals could petition in mental health court for annulment of charges, arrest, conviction, or sentence; forced certain employees, interviewees, or applicants for licensure to undergo mental health evaluations to gain or retain employment or licensure; no longer required certain short term insurance plans to offer MHMI services; restricted firearm possession or ownership based on prior involuntary confinement; forced an immediate reduction of student's rights if deemed a threat to school safety (guilty until proven innocent); and, bestowed additional power to potentially untrained medical professionals for purposes of commitment, detainment, or treatment.
3. Restricted privacy- allowed for disclosure of mental health records without consent or permission from individual, applicant, or licensee; forced certain applicants to undergo mental health evaluations and allowed the results to be used against them during hiring; forced offenders to provide waivers and/or authorizations allowing the release of their records; and, certain teaching applicants required to discuss their mental health during interviews.
4. Restricted resources- reduced Medicaid eligibility for certain individuals with MHMI conditions.

Bills also contained structural stigma in their language:

1. Labeling- the following words or phrases were lifted directly from the language and were all referring to people with MHMI conditions- an insane or incompetent person; the mentally ill; an abused senior; emotionally disturbed children, the alcoholic and the drug

addicted; intravenous drug user; mentally impaired; severely impaired person; medically frail; detained or committed individuals; gravely disabled; behaviorally disabled juveniles; criminogenic superutilizers of mental health resources; menace; mentally sick; consumer; and, financially vulnerable. Many other phrases in the language of bills could be considered stigmatic, but did not fit the criteria for the coding scheme (e.g., referring to outdated names of MHMI laws, such as the Mental Hygiene Law).

NOTE: While not directly referring to people with MHMI conditions, labeling language such as mentally retarded, mentally disabled, etc. were still being used in the language of state legislation.

2. Stereotyping- people with MHMI conditions were presented as *dangerous*: danger to themselves or others, sexually violent, or threats to school safety; *lacking in mental capacity*- mentally incompetent, maladjusted, dysregulated, or possessing deficits in processing; *unable to follow social roles*- unemployable, financially vulnerable, incapable of managing their own affairs, dysfunctional in mainstream society, or unable to make their own treatment decisions; *difficult to treat*- mental illness is permanent and debilitating, gravely disabling, and medically fragile; *at fault* for their own conditions; and, *chronic superutilizers* of the system.
3. Separation- implied fundamental differences between those with MHMI conditions and those without; physically separated people with MHMI conditions from the rest of society- segregation in housing grants, segregation in service delivery (institutions, hospitals, outpatient); and, excluded certain individuals from inmate work crews and reentry employment.

4. Status loss- implied fundamental, hierarchical differences- people with MHMI conditions are less than, have problems that need to be fixed, or are failing in some way; sought to obtain mental health records as evidence to reduce status (e.g., protective orders, loss of firearms); portrayed as gravely disabled- maladaptive skills or skill deficits, significantly impaired, cannot perform activities of daily living, unable to attend to basic needs, have mental diseases/defects, not competent to proceed due to psychiatric illnesses; sought employment restrictions and limitations; restricted rights for foster care youth in state hospitals (did not restrict the rights of their foster siblings at 'home'); broadened commitment criteria to enable easier commitments; restricted Medicaid eligibility; and excluded certain individuals from work crews, which reduced their income.
5. Discrimination- disadvantaged people with MHMI conditions by restricting possession or ownership of firearms; lengthened period of time required before allowing petitions for annulment of charges in mental health court; limited Medicaid eligibility; allowed potentially untrained individuals to make custody or detainment decisions based on suspicion or probable cause; forced an immediate reduction of student's rights if deemed a threat to school safety (guilty until proven innocent); forced certain applicants to undergo mental health evaluations, which could be used against them during hiring; excluded certain individuals from work crews; increased community supervision to prevent recidivism of MHMI resources; no longer required certain short term insurance plans to offer MHMI services or employ enough providers; and disadvantaged potential guardians who received poor mental evaluations or were deemed not of "sound mind".

Table 7

Textual Examples of Structural Stigma in State MHMI Legislative Proposals

Independent Variable	Legislative Examples	Quotations
Structural Stigma- Effect		
Restricted Liberties	<ul style="list-style-type: none"> ● Forced MHMI treatment or examinations ● Forced medication adherence ● Restrictions on firearm possession and ownership ● Broadened criteria for involuntary commitment ● Restricted rights of wards versus guardians ● Forced transportation- law enforcement involvement if required evaluation missed ● Broadened criteria for temporary detention orders (TDOs) 	<ul style="list-style-type: none"> ● <i>...requiring the person to receive medical, psychiatric or psychological treatment, including, without limitation, treatment for alcohol or drug abuse or a mental illness</i> ● <i>The board may require...an examination to evaluate the extent of the physical illness, physical condition, or behavioral or mental health disorder</i> ● <i>...an immediate family member or a peace officer may file a verified petition...for an injunction that prohibits a person from possessing, controlling, owning or receiving a firearm</i> ● <i>The judge may... order the defendant to submit to an examination by an expert</i> ● <i>Order the respondent to be examined without unnecessary delay by a qualified mental health professional to determine whether the respondent meets the criteria for court-ordered assisted outpatient treatment</i> ● <i>A guardian may limit, supervise, or restrict communication or visitation between the ward and a person</i> ● <i>After a child has been taken into shelter care...the department shall have the right to authorize a medical or mental health evaluation</i> ● <i>If the parent denies consent or is unable to be contacted, the department shall have the right to authorize treatment</i> ● <i>...if it comes to the court's attention that the individual will not make himself or herself available for an evaluation, the court may order law enforcement to transport the individual for the mental health evaluation</i>
Restricted Protections Against Discrimination	<ul style="list-style-type: none"> ● Lengthened period of time required before allowing petitions for annulment of charges in mental health court ● Forced evaluations to gain or retain employment or licensure ● Some short-term insurance plans no longer required to offer MHMI services ● Prior involuntary confinement used to restrict firearm possession/ownership ● School safety- immediate reduction in student rights if suspect; guilty until proven innocent ● Additional power given to medical professionals for commitment, detainment, or treatment, who may not have proper training 	<ul style="list-style-type: none"> ● <i>When a peace officer observes a person engaging in behavior which gives the peace officer reasonable suspicion to believe that the person may be suffering from a mental illness...the police officer may place the person in protective custody</i> ● <i>If the board suspects that the physical or mental health of any applicant is at risk to jeopardize or endanger those who seek assistance from the applicant, the board may require the applicant to be examined by a competent examiner selected by the board</i> ● <i>If the examiner confirms that the person's physical or mental health is at risk...the board may deny the application for a license</i> ● <i>...a physician, physician assistant, advanced practice registered nurse, or hospital is not liable in damages in a civil action, and shall not be made subject to disciplinary action by any entity with licensing or other regulatory authority, for doing either of the following: (1) Failing to discharge or to allow a patient to leave the facility if the physician, physician assistant, advanced practice registered nurse, or hospital believes...that the patient has a mental health condition that threatens the safety of the patient or others</i>
Restricted Privacy	<ul style="list-style-type: none"> ● Disclosure of mental health records without consent or permission ● Mental health evaluation results distributed and used for employment decisions ● Forced offender waivers and authorizations allowing the release of records ● Request of mental health records without consent, to be used for employment or licensing decisions 	<ul style="list-style-type: none"> ● <i>...to authorize mental health professionals to disclose mental health information when necessary to request an extreme risk protection order and to require the disclosure of mental health information</i> ● <i>The offender shall provide a written waiver and authorization...to allow the release of any clinical, treatment or program information, including...assessments related to mental health and risk and needs assessments</i> ● <i>In addition to ordering a physical or mental examination or an addiction evaluation, the board may...obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent</i>

	<ul style="list-style-type: none"> Teaching applicants required to discuss their mental health in interviews 	<ul style="list-style-type: none"> The rules and regulations also shall include a requirement that the board...notify the person of its intention to discuss the person's character, professional competence, or physical or mental health in an executive session The minor's parents or guardian, the prosecutor, defense attorney, and guardian ad litem, shall cooperate, by executing releases of information when necessary, in providing the relevant information and materials to the forensic evaluator, including: (i) medical records; (ii) prior mental evaluations; or (iii) records of diagnosis or treatment of substance abuse disorders. (b) The minor shall cooperate, by executing a release of information when necessary
Restricted Resources	<ul style="list-style-type: none"> Reduction in Medicaid eligibility 	<ul style="list-style-type: none"> Overall bill seeks to limit Medicaid eligibility and therefore services
Structural Stigma- Language		
Labeling	<ul style="list-style-type: none"> An insane or incompetent person Mentally ill Abused senior Emotionally disturbed The alcoholic and the drug addicted Intravenous drug users Severely impaired person Medically frail Detained or committed individuals Gravely disabled Behaviorally disabled juveniles Criminogenic superutilizers of mental health resources Menace Mentally sick Consumer Mentally impaired Financially vulnerable 	<ul style="list-style-type: none"> ...(3) is not guilty in a criminal case by reason of insanity, mental disease or defect; (3.5) is guilty but mentally ill ...treatment of addicted pregnant women, addicted mothers and their children Individual Care Grants for Mentally Ill Children ...including services for the alcoholic and the drug addicted ...the victim is a severely impaired person Beneficiaries who are identified as medically frail ...determination that the person was insane or lacked the mental capacity to commit the crime charged "Gravely disabled" means a condition in which an individual, as a result of a mental disorder, as a result of the use of alcohol or other psychoactive chemicals, or both: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety ...who are emotionally disturbed A minor or an insane or incompetent person may file a claim within one hundred eighty days after the disability ceases ...mentally ill or intellectually disabled ...providing community supervision to reduce recidivism among criminogenic superutilizers of mental health resources. ...although an individual who is intellectually disabled may also be a person who is mentally ill "Person requiring treatment" means a person who is mentally ill ...or a guardian of the estate of a minor or of an incompetent "mental abnormality," a congenital or acquired condition of a person that affects the emotional or volitional capacity of the person in a manner that predisposes that person to the commission of criminal sexual acts to a degree that makes the person a menace to the health and safety of other persons "Not competent to proceed" means that a minor, due to a mental disorder, intellectual disability, or related condition as defined, lacks the ability... ...the words "insane", "insanity", "lunacy", "mentally sick", "mental disease" or "mental disorder" are used, such terms shall have equal significance to the words "mental illness" "Knowledgeable person" means an individual who has reason to believe that a mental health client or patient has the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm to or causing the death of a clearly identifiable potential victim or victims and who is either an immediate family member of the client or patient or an individual who otherwise personally knows the client or patient
Stereotyping	<ul style="list-style-type: none"> Dangerous to self or others- sexually violent, unsafe in schools Lacks mental capacity- mentally incompetent, cannot manage own affairs or make treatment decisions, helpless 	<ul style="list-style-type: none"> ...lacks the mental capacity to manage his or her own affairs An individual who has mental illness, and who as a result of that mental illness is unable to attend to those of his or her basic physical needs such as food, clothing, or shelter that must be attended to in order for the individual to avoid serious harm in the near future, and

- Maladjusted, dysregulated, deficits in processing, dysfunctional
- Mental health cannot improve- debilitating impairment, permanent disability, gravely disabled
- Criminogenic superutilizers of resources, takes advantage of the system
- At fault for condition
- Not employable, financially vulnerable
- Medically frail

who has demonstrated that inability by failing to attend to those basic physical needs

- *...lead to debilitating conditions and permanent disability*
- *...manage their condition and avoid potentially life-long debilitating symptoms*
- *Untreated maternal mental health conditions significantly and negatively impact the short-term and long-term health and well-being of affected women and their children*
- *...health care, treatment, and other measures to correct or ameliorate defects and chronic conditions discovered thereby*
- *... "person with severe mental illness" means a person who has schizophrenia, a schizoaffective disorder, or a bipolar disorder and, as a result of that disorder, has active psychotic symptoms that substantially impair the person's capacity to: (1) appreciate the nature, consequences, or wrongfulness of the person's conduct; or (2) exercise rational judgment in relation to the person's conduct*
- *"Mentally ill person" or "person who is mentally ill" means an individual with an organic, mental, or emotional disorder that substantially impairs the capacity to use self-control, judgment, and discretion in the conduct of personal affairs and social relations*
- *...mental abnormality or personality disorder that makes the individual likely to engage in predatory sexually violent offenses*
- *"Mental disorder" means a serious emotional and mental disturbance that severely limits a minor's development and welfare over a significant period of time*
- *... "financially vulnerable adult" means an individual to whom one or more of the following apply: ... (B) incapable, by reason of: (i) mental illness; (ii) intellectual disability; (iii) dementia; or (iv) other physical or mental incapacity*
- *A threat assessment team shall: (1) Obtain training from local law enforcement or mental health service providers on how to assess individuals exhibiting threatening or disruptive behavior... (2) Conduct threat assessments based on dangerous or threatening behavior of individuals in the school, home, or community setting*
- *"Person requiring treatment" means a person who because of his or her mental illness or drug or alcohol dependency: (1) poses a substantial risk of immediate physical harm... (2) poses a substantial risk of immediate physical harm to another person or persons... (3) has placed another person or persons in a reasonable fear of violent behavior directed towards such person or persons or serious physical harm to them as manifested by serious and immediate threats, (4) is in a condition of severe deterioration such that, without immediate intervention, there exists a substantial risk that severe impairment or injury will result to the person, or (5) poses a substantial risk of immediate serious physical injury to self or death as manifested by evidence that the person is unable to provide for and is not providing for his or her basic physical needs*

Separating

- Fundamental difference between those with MHMI conditions and those without
- Lack of integration in housing- grant with supports only for adults with serious mental illness, separates them from general public
- Lack of integration in institutions- institutions solely for MHMI; institutions restricted from providing MHMI services
- Exclusion from work crews

- *...pay for substance abuse and/or mental health services in institutions for mental disease*
- *...except to persons in an institution for mental diseases*
- *No hospital, center, or institution, or part of any hospital, center, or institution, to provide inpatient, outpatient, or other service designed to contribute to the care and treatment of the mentally ill or intellectually disabled*
- *There is appropriated...the sum of \$1,350,000... to establish two substance abuse specialty shelters and one mental health specialty shelter to provide temporary housing and specialized homecare services for homeless individuals*
- *The number of prisoners removed from disciplinary and non-disciplinary segregation, respectively, due to mental decompensation*
- *...a housing with supports for adults with serious mental illness grant program*
- *...pay for substance abuse and/or mental health services in institutions for mental disease*

Status Loss	<ul style="list-style-type: none"> ● They are less than, somethings wrong, they have problems that need to be fixed, they are failing ● Maladaptive skills or skills deficits due to a psychiatric illness ● Using mental health records as evidence to reduce status (protective orders, loss of firearms) ● Gravely disabled- significantly impaired, cannot perform activities of daily living, unable to attend to basic needs, have mental diseases/defects, not competent to proceed ● Limitations on employment ● Foster care rights unavailable to youth in state hospitals ● Less restricted commitment criteria ● Loss of Medicaid ● Excluded from work crews, income 	<ul style="list-style-type: none"> ● <i>"Mental illness" means a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life</i> ● <i>...enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness; Psychiatric rehabilitation services for children combine psychotherapy to address internal psychological, emotional, and intellectual processing deficits</i> ● <i>...targeted to the specific deficits or maladaptations of the child's mental health disorder nature of their emotional, behavioral, or social dysfunction</i> ● <i>Early and periodic screening and diagnosis of individuals who are under the age of twenty-one to ascertain their physical or mental defects</i> ● <i>...while not meeting the standard to be found not guilty by reason of mental disease or defect</i> ● <i>"Not competent to proceed" means that a minor, due to a mental illness, intellectual disability, or related condition, or developmental immaturity, lacks the ability to: (a) understand the nature of the proceedings against them or...(b) consult with counsel and participate in the proceedings against them with a reasonable degree of rational understanding</i> ● <i>Adjudicated as a person with a mental disability" means the person is the subject of a determination by a court, board, commission or other lawful authority that the person, as a result of marked subnormal intelligence, or mental illness, mental impairment, incompetency, condition, or disease</i>
Discrimination	<ul style="list-style-type: none"> ● Disadvantaged with firearms ● Lengthened period of time required before allowing petitions for annulment of charges in mental health court ● Untrained individuals given power to make detention, commitment decisions based on probable cause ● Limits in Medicaid ● Loss of student rights if a suspect ● Required mental health examinations used against them in employment decisions ● Excluded from work crews ● Supervised to reduce recidivism among criminogenic superutilizers of mental health resources ● Potential guardians not of "sound mind" or with a poor "mental evaluation", disadvantaged in the guardianship process ● Short term insurance not required to cover MH or employ enough providers 	<ul style="list-style-type: none"> ● <i>Sibling youth in foster care, except youth in the custody of the division of youth services...or a state hospital for persons with mental health disorders, shall enjoy the following rights...</i> ● <i>This section does not require a group or individual insurance policy or agreement to offer mental health benefits</i> ● <i>The preferred provider plan is sufficient in number and types of providers (other than mental health and substance abuse treatment providers) to assure covered individuals' access to all health care services without unreasonable delay</i> ● <i>The court may consider such placement if the offender (a) is a male or female offender convicted of a felony offense in a district court, (b) is medically and mentally fit to participate</i> ● <i>Any person of full age and sound mind may execute a verified petition for the voluntary appointment of a conservator of the person's property upon the express condition that such petition shall be acted upon by the court only upon the occurrence of...a described condition of the mental or physical health of the petitioner</i>

Bivariate Results

Bivariate results for research question #1 are presented for the purposes of describing the relationships between legislative factors (IVs) and two variables representing structurally stigmatic legislation (DVs). The variables included in all bivariate analyses were based on past

theory and research. For this dissertation, crosstabulations are provided for description and context, and chi-square and Cramer’s V tests were run to examine relationships between categorical variables. The chi-square statistic measured the associations between variables and was used to inform the regression model, while Cramer’s V assessed the strength of each association.

Table 8 is a contingency table that presents the distributions of the IVs, broken down by variables of structural stigma. Once again, MHMI bills were 18% (n=36) structurally stigmatic in potential effect and 19% (n=38) structurally stigmatic in language overall. Among the bills used in analyses that were structurally stigmatic in their potential effect, 77% (n=23) were introduced by males, 60% (n=18) by Republicans, 70% (n=21) by the majority party of the chamber of bill introduction, 75% (n=27) in state Houses of Representatives, and 69% (n=25) as material-procedural. Among the bills used in analyses that were structurally stigmatic in their language, 77% (n=20) were introduced by males, 61% (n=17) by Republicans, 79% (n=22) by the majority party of the chamber of bill introduction, 61% (n=23) in state Houses of Representatives, and 63% (n=24) as material-procedural.

Table 8

Crosstabulations between Legislative Factors and Structural Stigma

Independent Variable	Structural Stigma					
	Potential Effect ^c			Language ^d		
	No N (%)	Yes N (%)	Total N (%)	No N (%)	Yes N (%)	Total N (%)
Legislator Demographics						
Majority Gender ^a						
Female	37 (22.6)	2 (1.2)	39 (23.8)	33 (20.1)	6 (3.7)	39 (23.8)
Male	102 (62.2)	23 (14.0)	125 (76.2)	105 (64.0)	20 (12.2)	125 (76.2)

Total	139 (84.8)	25 (15.2)	164 (100.0)	138 (84.1)	26 (15.9)	164 (100.0)
Majority Political Party ^b						
Republican	54 (32.3)	18 (10.8)	72 (43.1)	55 (32.9)	17 (10.2)	72 (43.1)
Democrat	83 (49.7)	12 (7.2)	95 (56.9)	84 (50.3)	11 (6.6)	95 (56.9)
Total	137 (82.0)	30 (18.0)	167 (100.0)	139 (83.2)	28 (16.8)	167 (100.0)
Political Party- Maj/Min Status ^b						
Minority	43 (25.7)	9 (5.4)	52 (31.1)	46 (27.5)	6 (3.6)	52 (31.1)
Majority	94 (56.3)	21 (12.6)	115 (68.9)	93 (55.7)	22 (13.2)	115 (68.9)
Total	137 (82.0)	30 (18.0)	167 (100.0)	139 (83.2)	28 (16.8)	167 (100.0)
Institution Characteristics						
Chamber						
Lower- House	87 (43.5)	27 (13.5)	114 (57.0)	91 (45.5)	23 (11.5)	114 (57.0)
Upper- Senate	77 (38.5)	9 (4.5)	86 (43.0)	71 (35.5)	15 (7.5)	86 (43.0)
Total	164 (82.0)	36 (18.0)	200 (100.0)	162 (81.0)	38 (19.0)	200 (100.0)
Bill Characteristics						
Typology						
Symbolic						
No	148 (74.0)	35 (17.5)	183 (91.5)	148 (74.0)	35 (17.5)	183 (91.5)
Yes	16 (8.0)	1 (0.5)	17 (8.5)	14 (7.0)	3 (1.5)	17 (8.5)
Total	164 (82.0)	36 (18.0)	200 (100.0)	162 (81.0)	38 (19.0)	200 (100.0)
Material- Procedural						
No	67 (33.5)	11 (5.5)	78 (39.0)	64 (32.0)	14 (7.0)	78 (39.0)
Yes	97 (48.5)	25 (12.5)	122 (61.0)	98 (49.0)	24 (12.0)	122 (61.0)
Total	164 (82.0)	36 (18.0)	200 (100.0)	162 (81.0)	38 (19.0)	200 (100.0)
Material- Substantive						
No	113 (56.5)	26 (13.0)	139 (69.5)	112 (56.0)	27 (13.5)	139 (69.5)
Yes	51 (25.5)	10 (5.0)	61 (30.5)	50 (25.0)	11 (5.5)	61 (30.5)
Total	164 (82.0)	36 (18.0)	200 (100.0)	162 (81.0)	38 (19.0)	200 (100.0)

Note. ^a N=164. ^b N=167. ^c Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in one or multiple categories, it was coded as structurally stigmatic in potential effect. ^d Binary variable

(No=0, Yes=1); if a bill was coded as stigmatic in three out of five categories, it was coded as structurally stigmatic in language.

Table 9 presents bivariate results regarding the associations between legislative factors and both structural stigma variables. For the current study, structural stigma- potential effect was significantly associated with (1) gender, $\chi^2 (1, N = 164) = 4.05, p = .044$; (2) political party, $\chi^2 (1, N = 167) = 4.25, p = .039$; and (3) chamber, $\chi^2 (1, N = 200) = 5.80, p = .016$. After examining the observed versus expected counts of stigmatic bills, the results indicated that males, Republicans, and members of state Houses of Representatives were more likely to introduce bills that were structurally stigmatic in their potential effect. The strength of these relationships is debatable, as the interpretation of effect size depends on the statistician: .11-.30 is considered weak or moderate, depending on the author (Cohen, 1988; Healey, 2015). However, according to Cohen’s (1988) guidelines, which are widely used in the field, gender ($V = .16, p = .044$), political party ($V = .16, p = .039$), and chamber ($V = .17, p = .016$) all had weak associations ($df=1$: weak=.10-.30). Finally, structural stigma- language was significantly associated with political party, $\chi^2 (1, N = 167) = 4.25, p = .039$, and was also weakly associated ($V = .16, p = .039$) (Cohen, 1988). Once again, Republicans were more likely to introduce bills that were structurally stigmatic, this time in their language.

Table 9

Associations between Legislative Factors and Structural Stigma

Independent Variable	Structural Stigma					
	Potential Effect ^c			Language ^d		
	χ^2	<i>p</i> value	Cramer’s V (<i>p</i> value)	χ^2	<i>p</i> value	Cramer’s V (<i>p</i> value)
Legislator Demographics						

Majority Gender ^a	4.05	.044*	.16 (.044)*	0.01	.927	.01 (.927)
Majority Political Party ^b	4.25	.039*	.16 (.039)*	4.25	.039*	.16 (.039)*
Political Party- Maj/Min ^b	0.02	.882	.01 (.882)	1.48	.224	.09 (.224)
Institution Characteristics						
Chamber	5.80	.016*	.17 (.016)*	0.24	.626	.04 (.626)
Bill Characteristics						
Typology						
Symbolic	1.85	.174	.10 (.174)	0.02	.882	.01 (.882)
Material- Procedural	1.32	.251	.08 (.251)	0.09	.762	.02 (.762)
Material- Substantive	0.15	.695	.03 (.695)	0.05	.817	.02 (.817)

Note. ^a N=164. ^b N=167. ^c Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in one or multiple categories, it was coded as structurally stigmatic in potential effect. ^d Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in three out of five categories, it was coded as structurally stigmatic in language.

* $p < .05$.

Multivariate Results

Models

Multivariate analyses were conducted to find patterns and relationships between more than two variables at a time. For research question #1, binary logistic regression was used to determine if one or more of the IVs predicted either of the structural stigma variables. While the inclusion of IVs in the bivariate analyses were based on past research and theory, these regression models were created using the bivariate results of this study; specifically, chi-square tests were run, and every significant IV was added to the model (Williams et al., 2008). The first model used three IVs that were significantly associated with structural stigma- potential effect at the bivariate level, including (1) gender, (2) political party- sponsor, and (2) chamber. The

Variance Inflation Factor (VIF) scores ranged from 1.001-1.013, indicating low multicollinearity between the IVs (Bowerman & O'Connell, 1990; Hair et al., 2010; Myers, 1990). The Hosmer–Lemeshow goodness-of-fit test yielded a $\chi^2(5)$ of 1.968 and was insignificant ($p = .854$), confirming the null hypothesis of a good model fit to the data (Peng et al., 2002). The second model used one IV significantly associated with structural stigma- language, which was (1) political party- sponsor. VIF scores did not need to be checked, as there was only one IV in the second model. The Hosmer-Lemeshow goodness-of-fit test did not apply for model #2, as there was only one categorical predictor ($\chi^2(0)$ of .000, $df=0$, $p = N/A$). Thus, to determine model fit, the Nagelkerke R^2 coefficient was examined; the model was significant at the .05 level ($p = .042$), indicating a poor model fit (Nagelkerke, 1991).

Results

The binary logistic regression results had several outputs in SPSS 26. First, beta coefficients (B) represented the predicted change in log odds for every one-unit increase on a predictor (IV). Second, Exp(B)s, or odds ratios, indicated a change in odds of being in one of the categories of the DV when the value of an IV increased by one unit. Odds ratios are the exponentiations of betas, and their interpretations are interconnected; positive betas indicate increased odds of target group membership, while negative betas indicate decreased odds in target group membership. Finally, Wald tests examined the null hypothesis (that each IV could be dropped from the model without affecting the results) and produced a chi-square statistic with a corresponding p value for each IV (Tabachnick & Fidell, 2013).

Tables 10-11 present the multivariate findings for both models relevant to research question #1. According to the Wald p values, all variables were insignificant in model #1 (Table 10). However, the values of the beta coefficients indicated valuable information about the directions

of the relationships, which fit the bivariate results for research question #1. Notably, there was a positive relationship between gender (OR = 3.903, $p = .077$) and structural stigma- potential effect (with a moderately large odds ratio), while both political party (OR = -0.660, $p = .152$) and chamber (OR = -0.693, $p = .159$) were negatively associated. These findings confirm the bivariate results that males, Republicans, and members of state Houses of Representatives were more likely to introduce bills that were structurally stigmatic in potential effect. In model #2 (Table 11), while the model was not a good fit, a sponsor's political party (OR = 0.424, $p = .043$) significantly predicted structural stigma in the language of bills. Specifically, Republicans were more likely to introduce bills that were structurally stigmatic in language.

Table 10

Predictors of Structural Stigma- Potential Effect (N=167)

Independent Variable	B [S.E.]	Wald	OR [95% CI]	p value
Regression Model ^a				
Majority Gender	1.362 [.771]	3.120	3.903 [0.861-17.689]	.077
Majority Political Party	-0.660 [.461]	2.049	0.517 [0.210-1.276]	.152
Chamber	-0.693 [.492]	1.984	0.500 [0.191-1.312]	.159

^a Hosmer-Lemeshow Test: $p = .854$

* $p < .05$.

Table 11

Predictors of Structural Stigma- Language (N=167)

Independent Variable	B [S.E.]	Wald	OR [95% CI]	p value
Regression Model				
Political Party- Sponsor	-0.859 [.424]	4.102	0.424 [0.185-0.973]	.043*

* $p < .05$.

Research Question #2: *How do sponsor, institutional, or bill-related factors influence state MHMI legislative voting outcomes?*

The voting behavior of policymakers is often influenced by a series of factors, both internal and external to the individual legislator. Understanding what influences their MHMI voting in particular, may help advocates to better target their efforts. Research question #2 examined each subset of sponsor, institutional, and bill-related factors that may affect or even predict MHMI voting outcomes.

Bivariate Results

Bivariate results for research question #2 are presented to describe the relationship between these potentially influential factors (IVs) and current bill status (DV). Crosstabulations, chi-square tests of association, and Cramer's V tests were run to examine relationships between categorical variables.

Table 12 is a contingency table that presents the distributions of the IVs by bill status as well as the results of the chi-square analysis. Among the bills used in the analyses, 75% (n=57) were passed by males, 52% (n=41) were passed by Republicans, 80% (n=63) were passed by the majority party of the chamber of bill introduction, 59% (n=59) were passed in Houses of Representatives, 60% (n=60) were passed with material- procedural typologies, 18% (n=18) were structurally stigmatic in potential effect, and 26% (n=26) were structurally stigmatic in language.

For the current study, the status of MHMI bills was significantly associated with (1) political party, $\chi^2 (1, N = 200) = 4.718, p = .030$; (2) political party- maj/min status, $\chi^2 (1, N = 200) = 8.284, p = .004$; and (3) structural stigma- language, $\chi^2 (1, N = 200) = 6.368, p = .012$, including (3a) stereotyping, $\chi^2 (1, N = 200) = 8.287, p = .004$; and (3b) discrimination, $\chi^2 (1, N = 200) =$

5.531, $p = .019$. After examining the observed and expected counts of each variable, the results indicated that passed bills were more likely to be introduced by Republicans and members of the majority party in the chamber of the bill's introduction as well as with the presence of structurally stigmatic language. According to Cohen (1988) political party ($V = .17, p = .030$), structural stigma- language ($V = .18, p = .012$), and political party- maj/min status ($V = .22, p = .004$) all had weak associations.

Table 12

Associations between Legislative Factors and Bill Status

Independent Variable	Bill Status			χ^2	p value	Cramer's V (p value)
	Fail N (%)	Pass N (%)	Total N (%)			
Legislator Demographics						
Majority Gender ^a	-	-	-	0.12	.733	.03 (.733)
Female	20 (12.1)	19 (11.6)	39 (23.8)	-	-	-
Male	68 (41.5)	57 (34.8)	125 (76.2)	-	-	-
Total	88 (53.7)	76 (46.3)	164 (100.0)	-	-	-
Majority Political Party ^b	-	-	-	4.72	.030*	.17 (.030)*
Republican	31 (18.6)	41 (24.6)	72 (43.1)	-	-	-
Democrat	57 (34.1)	38 (22.8)	95 (56.9)	-	-	-
Total	88 (52.7)	79 (47.3)	167 (100.0)	-	-	-
Political Party- Maj/Min Status ^b	-	-	-	8.28	.004**	.22 (.004)**
Minority	36 (21.6)	16 (9.6)	52 (31.1)	-	-	-
Majority	52 (31.1)	63 (37.7)	115 (68.9)	-	-	-
Total	88 (52.7)	79 (47.3)	167 (100.0)	-	-	-
Institution Characteristics						
Chamber	-	-	-	0.33	.568	.04 (.568)
Lower- House	55 (27.5)	59 (29.5)	114 (57.0)	-	-	-
Upper- Senate	45 (22.5)	41 (20.5)	86 (43.0)	-	-	-
Total	100 (50.0)	100 (50.0)	200 (100.0)	-	-	-
Bill Characteristics						
Typology	-	-	-	-	-	-
Symbolic	8 (4.0)	9 (4.5)	17 (8.5)	0.06	.800	.02 (.800)
Material- Procedural	62 (31.0)	60 (30.0)	122 (61.0)	0.08	.772	.02 (.772)
Material- Substantive	30 (15.0)	31 (15.5)	61 (30.5)	0.02	.878	.01 (.878)
Total	100 (50.0)	100 (50.0)	200 (100.0)	-	-	-
Structural Stigma- Potential Effect ^c	-	-	-	0.00	1.00	.00 (1.000)
Restricted Liberties	14 (7.0)	10 (5.0)	24 (12.0)	0.76	.384	.06 (.384)
Restricted Protections Against Discrimination	7 (3.5)	11 (5.5)	18 (9.0)	0.98	.323	.07 (.323)

Restricted Privacy	3 (1.5)	5 (2.5)	8 (4.0)	0.52	.470	.05 (.470)
Restricted Resources	1 (0.5)	0 (0.0)	1 (0.5)	1.01	.316	.07 (.316)
Structurally Stigmatic- Potential Effect ^c	18 (9.0)	18 (9.0)	36 (18.0)	-	-	-
Non-structurally Stigmatic- Potential Effect	82 (41.0)	82 (41.0)	164 (82.0)	-	-	-
Total	100 (50.0)	100 (50.0)	200 (100.0)	-	-	-
Structural Stigma- Language ^d	-	-	-	6.37	.012*	.18 (.012)*
Labeling	6 (3.0)	14 (7.0)	20 (10.0)	3.56	.059	.13 (.059)
Stereotyping	14 (7.0)	31 (15.5)	45 (22.5)	8.29	.004**	.20 (.004)**
Separating	22 (11.0)	28 (14.0)	50 (25.0)	0.96	.327	.07 (.327)
Status Loss	12 (6.0)	17 (8.5)	29 (14.5)	1.01	.315	.07 (.315)
Discrimination	7 (3.5)	18 (9.0)	25 (12.5)	5.53	.019*	.17 (.019)*
Structurally Stigmatic-Language ^d	12 (6.0)	26 (13.0)	38 (19.0)	-	-	-
Non-structurally Stigmatic- Language	88 (44.0)	74 (37.0)	162 (81.0)	-	-	-
Total	100 (50.0)	100 (50.0)	200 (100.0)	-	-	-

Note. ^a $N=164$. ^b $N=167$. ^c Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in one or multiple categories, it was coded as structurally stigmatic in potential effect. ^d Binary variable (No=0, Yes=1); if a bill was coded as stigmatic in three out of five categories, it was coded as structurally stigmatic in language.

* $p < .05$. ** $p < .01$.

Multivariate Results

Model

Binary logistic regression was conducted to determine if one or more of the IVs predicted current bill status. The current study used three IVs that were significantly associated with current bill status at the bivariate level, including (1) political party- sponsor, (2) political party- maj/min status, and (3) structural stigma- language. The Variance Inflation Factor (VIF) scores ranged from 1.009-1.165, indicating low multicollinearity between the IVs (Bowerman & O'Connell, 1990; Hair et al., 2010; Myers, 1990). The Hosmer–Lemeshow goodness-of-fit test yielded a $\chi^2(5)$ of 8.436 and was insignificant ($p = .134$), confirming the null hypothesis of a good model fit to the data (Peng et al., 2002).

Results

Table 13 presents the multivariate findings for research question #2. Notably, political party-maj/min status (OR = 2.307, $p = .029$) and structural stigma- language (OR = 2.461, $p = .046$) were significant predictors of current bill status in the model. Both odds ratios were larger than 1, reflecting positive beta coefficients and representing positive relationships between variables. Further, significant Wald p values and larger chi-square statistics supported the significance of the findings. These results indicate that state MHMI bills were approximately 2.5 times more likely to pass if they were structurally stigmatized in language and were introduced by members of the majority party in the chamber of the bill’s introduction. Further, while not significant, there was also a negative relationship between political party- sponsor and current bill status (OR = .736, $p = .358$), indicating that Republicans were more likely to pass MHMI legislation.

Table 13

Predictors of MHMI Policy Outcomes (N=167)

Independent Variable	B [S.E.]	Wald	OR [95% CI]	p value
Regression Model ^a				
Political Party- Sponsor	-.320 [.348]	.845	0.73 [0.367-1.437]	.358
Political Party- Maj/Min Status	.836 [.382]	4.775	2.31 [1.090-4.881]	.029*
Structural Stigma- Language	.901 [.451]	3.985	2.46 [1.016-5.960]	.046*

^a Hosmer-Lemeshow Test: $p = .134$

* $p < .05$.

Chapter 5: Discussion

This dissertation's final chapter begins by summarizing the study, including the social problem, study methods, and results. Next, in-depth discussions of the findings are provided, in context with previous literature. Implications for social work policy practice and MHMI advocacy are then discussed, followed by a review of study limitations. In conclusion, the chapter discusses next steps and recommendations for future research that continues to explore mental healthcare gaps and examine structural stigma in the MHMI policy process.

Study Summary

Most individuals in need of mental healthcare will not receive it due to gaps in access and services (CVN & NCBH, 2018; SAMHSA, 2018). Policymakers have the power to close mental healthcare gaps through their voting (e.g., WHO et al., 2008), but critical bills and appropriations often fail. Consequently, people with MHMI conditions face significant barriers to care, which are frequently exacerbated by stigma (CVN & NCBH, 2018; WHO et al., 2008). Structural stigma in particular affects the policymaking process (Corrigan, Watson, et al., 2004) and is a significant contributor to unequal outcomes for people with MHMI conditions (Link et al., 2004). While past research has examined MHMI stigma in the attitudes of the individual, forms of structural stigma have been identified as critically underrepresented (Link et al., 2004). Understanding the nature of structural stigma in state legislatures as well as how structural stigma and other factors influence MHMI voting, may assist advocates in their attempts to address gaps in MHMI services and access.

Thus, the present study aimed to explore state MHMI legislative proposals with goals of exposing forms of structural stigma present in the language and potential effects of the bills as well as identifying patterns in MHMI voting outcomes. To achieve these aims, quantitative

content analysis was conducted on a stratified random sample of state MHMI legislation introduced during the Trump administration. Using an online database that allowed for cross-country, topical searches, over 15,000 bills were found and separated into groups based on political party and current status. Bills were then randomly selected until proportional to the state popular votes during the 2016 presidential election ($N=200$). Variables were operationalized using a combination of past research and theory, and bills were codified into frequencies that were summarized and assessed through bi- and multivariate tests of association. Results suggested that structural stigma is present in both the language and potential effects of MHMI bills across the country and is associated with variables of political party and gender. Further, two political party variables and structural stigma in the language of the bills were all significantly associated with current bill status. Finally, political party- maj/min status and structural stigma- language were both significant predictors of current bill status.

Findings

Study Highlights

The current study found that MHMI bills introduced during the Trump administration were often stigmatic in language and potential effect. Males and Republicans were more likely to introduce stigmatic legislation, while Republicans and members of the majority party were more likely to get bills passed. Finally, party majority status and structural stigma in the language of the bills predicted bill passage, a finding that to my knowledge is the first of its kind. Below, each finding is discussed in greater detail and contextualized through past research and theory.

Research Question #1: What is the nature of structural stigma in state MHMI legislative proposals?

Policy design theory suggests that the social construction of populations leads to the social construction of policymakers, which in turn leads to a socially constructed policy (Schneider & Sidney, 2009). Policies and norms that restrict the resources and opportunities of certain target populations are a form of structural stigma (Hatzenbuehler & Link, 2014). Structural stigma occurs when those in power enact policies negatively affecting certain populations (Pincus, 1996, 1999), such as forced treatments (e.g., mandatory participation), restricted opportunities, and limited rights (Corrigan & Shapiro, 2010; Pescosolido et al., 2007). Legislators who have adopted stigmatized social constructions of people with MHMI conditions can block funding, vote against beneficial initiatives, or introduce harmful bills that are structurally stigmatic in their language or potential effect. The current study took a snapshot of structural stigma present in recently introduced MHMI bills as well as examined the relationship between legislative factors and structural stigma, and the findings are discussed below.

Finding #1: MHMI Bills Were Structurally Stigmatic

Overall, 19% of bills were structurally stigmatic in language. Further, 18% of bills were structurally stigmatic in potential effect ($\mu=6.38\%$), which supports past research ($\mu=5.50\%$, Corrigan et al., 2005). Legislators may be unaware of the presence of structural stigma in the language and restrictions in their bills or they may have been socially constructed to stigmatize people with MHMI conditions, which is affecting their policy designs. Both are possible and imply recommendations for social workers, which are discussed in the implications section. However, according to policy design theory, if the MHMI policy designs were stigmatized as the data suggest, then their sponsors were also stigmatized due to how they were socially constructed to view MHMI issues. Thus, the section below focuses on plausible explanations for why

legislators may stigmatize people with MHMI conditions and how policymaker stigma presents in MHMI legislation.

Despite increased public awareness and knowledge surrounding MHMI issues, many Americans still hold stigmatizing attitudes toward people with MHMI conditions that have not decreased over time (Parcesepe & Cabassa, 2013). Legislators are members of the general public, and according to modified labeling theory, they generally would be socialized with similar attitudes and beliefs as the rest of society (Link et al., 1989). Phelan et al. (2008) suggested that structural stigma serves three functions in society: to keep stigmatized groups “down” through exploitation or domination, “in” through social norm enforcement or punishment, or “away” through avoidance or separation. As powerful members of the general public, legislators may stigmatize people with MHMI conditions due to several factors first reviewed in Chapter 1, including stereotypes of perceived dangerousness and unpredictability as well as attributions of cause or blame.

Perceived Dangerousness or Unpredictability. Similar to structural consequences of MHMI stigma found in past research (Corrigan & Shapiro, 2010; Pescosolido et al., 2007), the current study found that a number of bills restricted liberties by forcing treatments, mandating participation, and limiting certain rights. For example, certain states across the country forced individuals to sit for evaluations or receive treatment (i.e., medication or services), made attendance to programs mandatory with consequences for non-compliance, and restricted rights surrounding guardianship, firearms, and involuntary commitment.

These proposed restrictions suggest that policymakers consider people with MHMI conditions to be dangerous or unpredictable and unable to follow social roles on their own. Therefore, states have attempted to mandate social roles, force predictability, and limit decision

making, which in theory, would reduce unpredictability and the potential for dangerousness. Past research has revealed similar narratives, as individuals with MHMI conditions are frequently associated with unpredictability and violence in society (e.g., Martin et al., 2000; Phelan, Link et al., 2000), often due to portrayals in various media platforms (e.g., Corrigan et al., 2005; Wahl et al., 2002; Budenz et al., 2018). Consequently, individuals with MHMI conditions are often viewed as dangerous (e.g., Link et al., 1999; Pescosolido et al., 1999), despite the fact that they are no more dangerous than the general public (HHS, 2017) and are actually at higher risk of victimization (e.g., Choe et al., 2008; Desmarais et al., 2014). If policymakers view people with MHMI as dangerous or unpredictable, they may wish to increase predictability by (1) keeping them “down” through domination, discrimination, or status reduction, or (2) keeping them “away” through assigning labels and separating from the rest of society.

Attributions of Cause or Blame. Similar to past research, the current study found that certain bills reduced privacy and confidentiality, restricted resources (Corrigan et al., 2005), and reduced protections against discrimination in certain areas or systems involved in everyday life (e.g., employment, healthcare, etc.; Burton, 1990; Corrigan et al., 2005; Hemmens et al., 2002). Certain states restricted rights related to privacy by introducing bills that called for forced disclosure of MHMI records without consent or reduced confidentiality among applicants for employment, licensure, or reentry into society from confinement. In addition, certain states reduced protections against discrimination in the areas of criminal justice, employment, insurance, firearms, public schools, and involuntary commitment as well as restricted resources for Medicaid.

These legislative restrictions may involve assumptions surrounding cause, responsibility, and blame. For example, attribution theory discusses how individuals are internally motivated to

discover causal relationships and during this process, they make attributions or assumptions about the controllability and cause of an illness that lead to inferences about an individual's responsibility for their own condition (Weiner, 1980). These individual attributions can collectively assist in creating stigmatizing social constructions of entire populations, which can legitimate policies that intentionally or unintentionally exclude stigmatized groups (Corrigan et al., 2005). If a population with a disease or disorder becomes stigmatized due to collectively misinformed attributions, social policies can operationalize discrimination against them (Herek et al., 2003; Link & Hatzenbuehler, 2016). In terms of MHMI, much of the public believes that people with MHMI conditions are to blame for their own conditions and should be held responsible (Corrigan et al., 2000; Weiner et al., 1988); consequently, policies that include and protect people with MHMI conditions carry low public support (Bobo et al., 2012). If legislators adopt public opinion—that individuals with MHMI conditions are simply unequipped to healthily cope with life stressors and are thus responsible for their own conditions—they may be more likely to blame these individuals and punish them by introducing restricting policies that keep them “in” through social norm enforcement. The resulting disadvantages for people with MHMI conditions are evident in the literature and manifest in certain systems such as the criminal justice system (e.g., Link et al., 1992), healthcare (e.g., Mark et al., 2014), housing/employment (e.g., Wahl, 1999), etc.

Finding #2: Males and Republicans Introduce More Structurally Stigmatic MHMI Bills

A sponsor's political party was significantly associated with the presence of both structural stigma variables, while gender and chamber were significantly associated with structural stigma-potential effect. Specifically, stigmatizing bills were more likely to be introduced by males, Republicans, and members of the lower chamber (House). Also, the political party of the sponsor

predicted structural stigma: membership in the Republican party predicted structural stigma in the language of the bills. Finally, while insignificant ($p = .077$), males were four times more likely to introduce bills that were structurally stigmatic in potential effect. Given past research, these results are not surprising, as male gender (Corrigan & Watson, 2007) and conservative political identification (e.g., Deluca & Yanos, 2016) have been significantly associated with stigmatic attitudes toward mental illness.

Males may be more likely to introduce stigmatizing legislation due to their attitudes toward MHMI issues. Males have been found to be less accepting of people with mental illness as well as more likely to endorse discriminatory behavior (Farina, 1998). Further, in a 2012 systematic review on gender differences toward mental disorders, Holzinger et al. (2012) found that across the literature, men were consistently more likely than women to view mental illness as controllable and people with MHMI conditions as responsible for their own illnesses. The above aligns with traditional gender roles, as males historically have been socialized to view mental health help-seeking as a weakness, in direct opposition to masculine traits (Smith et al., 2018).

Republicans may be more likely to introduce stigmatizing legislation due to their political ideology. Conservatism and right-wing authoritarianism (RWA) were found to be significant predictors of mental health stigma in the literature (Deluca et al., 2018; Deluca & Yanos, 2016). For example, individuals self-reporting as conservative were more likely to view people with MI as dangerous (Phelan & Link, 2004) and poor in character (Watson et al., 2005), and were less likely to support government funding for MHMI services (Barry & McGinty, 2014). In addition, those with high scores on the RWA scale, an attitudinal measure correlating with economic and social conservatism (Altemeyer, 1996), were more likely to view people with mental illness as unpredictable and were less willing to make personal contact (Deluca & Yanos, 2016). Finally,

RWA was associated with hypothetical beliefs of harsher sentencing for people with mental illness (Fodor et al., 2008), lower evaluations for job candidates with schizophrenia (Fodor, 2006), and negative attitudes toward MHMI services (Furr et al., 2003).

Also of note, previous literature found that certain policymaker groups were more favorable toward vulnerable populations and issues of social welfare, including Democrats (Barrett & Cook, 1991), women (Poggione, 2004; Thomas, 1991), and African Americans (Bratton & Haynie, 1999). This does not necessarily mean that these demographic groups are completely devoid of MHMI stigma; it could instead be a difference in severity that presents in varying degrees toward people with MHMI conditions (e.g., punishment vs. inaction). For instance, in terms of funding, Corrigan and Watson (2003) note that conservative policymakers are often motivated by a tendency to punish individuals who are perceived as having personal responsibility for their problems by withholding resources, whereas liberals are likely to avoid tough allocation decisions altogether.

Research Question #2: How do sponsor, institutional, or bill-related factors influence state MHMI legislative voting outcomes?

Finding #3: Republicans and Members of Majority Parties Get MHMI Bills Passed

Aside from structural stigma, the other core construct of this study is legislative influence, or factors that influence the policy process and the outcomes of bills. Factors of influence could be characteristics internal to the individual legislator (e.g., gender, ideology, race/ethnicity) or outside forces external to the legislator (e.g., political party, public opinion, research). To my knowledge, the current study is one of the first to explore factors that influence MHMI voting outcomes specifically. Findings from research question #2 indicate that (1) a sponsor's political party, and (2) the status (majority/minority) of a sponsor's political party in the chamber

(House/Senate) in which their bill was introduced, were both significantly associated with MHMI bill status. Further, MHMI state legislation bills were roughly 2.5 times more likely to pass if they were introduced from the majority party in the sponsor's chamber (Republicans were more likely to get bills passed, but the p -value was not significant). As with research question #1, the findings related to research question #2 are discussed using past research and theory.

Political party affiliation has been found to influence legislator voting in past research (Cox & Poole, 2002; Davidson et al., 2013; Snyder & Groseclose, 2000). Affiliation to a certain party was linked to voting outcomes on issues relevant to social work, including tobacco product control (Anderson et al., 2007; Cohen et al., 2002) and social welfare (Barrett & Cook, 1991). It has been theorized that legislators seek to create and maintain a favorable reputation within their party, and that motivation leads to support of certain policies that reflect the preferences of the median in their party (Cox & McCubbins, 1993). While political party was associated with bill status in the current study, the relationship was insignificant in the regression model ($p = .358$). However, the beta coefficient did indicate a negative relationship, which would fit with the study's bivariate results in suggesting that the Republican party was associated with bill passage.

Party majority also affected the outcomes of bills in the current study and was the strongest predictor of MHMI bill status. Majority party agenda-control theory suggests that the median of the majority party in a respective chamber controls the political agenda of that party, and thus controls the nature of legislative outcomes (e.g., Cox & McCubbins 2002; Sinclair 1983). Lawrence et al. (2006) tested this theory and confirmed that legislative outcomes were indeed most often on the majority party's side of the chamber median. The current study also supports this theory, which may demonstrate additional utility when the topics of bills introduced from the

majority party deal with controversial issues or vulnerable populations that traditionally have received limited support.

As Republicans have controlled the federal landscape as well as the majority of legislatures (and their chambers) across the country over the last several years (National Conference of State Legislatures, 2020), it is unsurprising that the Republican party and party majority were both associated with MHMI bill status and that party majority was a significant predictor of successfully passed MHMI legislation. However, while these findings were significant and consistent with past research, it should be noted that future research should examine the potential impact of ideology, as several past studies have found that ideology is the strongest predictor of votes (e.g., Chressanthis et al., 1991; Levitt, 1996; Shor et al., 2018) and may mediate the relationship between political party and voting outcomes (Kingdon, 1989).

Finding #4: Structurally Stigmatic Bills are More Likely to Pass

Finally, structural stigma in the language of the bills was significantly associated with MHMI bill status. Further, MHMI state legislation bills were roughly 2.5 times more likely to pass if structurally stigmatic in language. To my knowledge, this is the first study to examine this relationship. Considering that the majority of legislators in the sample were male, and males were more likely to introduce structurally stigmatic MHMI legislation, it may have been easier for structurally stigmatic bills to get passed in general. However, gender was not significantly associated with bill status in any way in the current study, which opposed past research (Hogan, 2008; Poggione, 2004; Swers, 1998), yet could have been due to the lack of females represented in the sample overall (n=39). An alternative explanation to the relationship between structural stigma- language and bill status could be that both political party variables played a role. As Republicans and legislators in the majority party were more likely to introduce legislation with

stigmatizing language, and Republican legislators are in the majority in much of the country, it once again may have been easier for members of both populations to pass bills in general, including structurally stigmatic bills. Finally, most bills in the sample were material-procedural, or sought changes in processes or procedures, as opposed to symbolic or material-substantive. In my experience with reading legislation, these types of bills are typically much longer than other legislative typologies that seek to bring awareness to an issue or alter resources, as processes and procedures on average are often lengthy. Therefore, in a sample that included bills that may have been lengthier due to typology, there may have been additional opportunities for languages to be stigmatized. Future research should continue to explore the link between structural stigma in the language of the bills and bill outcomes in order to more thoroughly explore a potentially key relationship for social work. Two potential options could be further dissecting predictors and examining latent classes using latent class analysis or exploring the significant pathways in the regression model for any mediating legislative factors using structural equation modeling.

Implications

Findings from the current study provide implications for social workers and other advocates for better MHMI services in their efforts to reduce MHMI stigma and to influence the MHMI policy process.

Implications for MHMI Structural Stigma Reduction

The findings from research question #1 indicated that structural stigma is present in both the language and the potential effect of state MHMI legislation across the country, and certain factors affect the introduction of structurally stigmatic bills. Two possible explanations are that: (1) policymakers are unaware of the presence of MHMI structural stigma in their own writing and legislative goals, and/or (2) policymakers or the constituencies they represent have become

socially constructed as stigmatized toward people with MHMI conditions. Regardless, social workers need to commit to reducing mechanisms of MHMI structural stigma in state legislatures by implementing new and innovative techniques that are fundamentally based on past research.

Recommendation #1: Increase Awareness

If policymakers are truly unaware of structurally stigmatic elements in their own bills or agendas, then social workers should educate them. This requires dissemination of past and current studies to state legislators on the presence of structural stigma in state MHMI legislation. Further, to prevent future structurally stigmatic language, social workers should be more involved in the policy development process, including the authorship of the bills.

Recommendation #2: Social Reconstruction

While a lack of awareness on its own is plausible, the more likely and complicated scenario is that policymakers have been socially constructed to stigmatize people with MHMI conditions, which is affecting their policy designs. Past research has explored ways to reduce stigma in mental health, including education, protest, and personal contact (Corrigan & Penn, 1999; Rüsche et al., 2005). However, while these techniques have been effective in some cases, the reality is that stigmatizing attitudes persist (Pescosolido et al., 2010), as the focus continues to be on modifying the beliefs and attitudes of individuals, rather than the reduction of public or structural forms of stigma (Clair et al., 2016). Any approach must ultimately address the fundamental cause of stigma by changing the attitudes and beliefs of powerful groups that ultimately allow the elements of MHMI stigma to occur (Link & Phelan, 2001). Thus, social workers should target powerful groups (i.e., policymakers and the public) and seek to change their attitudes by socially reconstructing MHMI. HIV/AIDS provides a successful blueprint for social

reconstruction focused on discrediting stereotypes through a combination of research and the media.

HIV/AIDS. People with HIV/AIDS were often stereotyped as responsible for their own illnesses due to societal misconceptions surrounding the cause of the disease. Through scientific advances as well as the media's coverage of personal narratives, stereotypes were debunked through a change in public opinion, which led to new and favorable policies. People with MHMI conditions are similarly stereotyped, most notably as dangerous or at fault for their own illnesses due to stigmatized social constructions. Because public opinion influences policymakers and policymakers are members of the general public, stigma reduction efforts should follow the lead of successful HIV/AIDS campaigns and target both powerful groups to reduce stereotypes through a combination of research and the media.

The literature suggests that research dissemination is effective, especially when distributing a combination of quantitative and qualitative data (Brownson et al., 2009). Further, the media brings attention to social problems, which can change public opinion and force policymaker action (Buse et al., 2005; Sample & Kadleck, 2008). Both of these tools were effective in reducing stigma related to HIV/AIDS. For example, during the epidemic, 60% of Americans said most of what they knew about the disease came from the media (Kaiser Family Foundation, 2011). Quantitatively, researchers used the media to reduce myths and disseminate their findings publicly (Epstein, 1996). Qualitatively, the story of Ryan White socially reconstructed the target population as blameless and changed the societal narrative about the controllability of the disease (Schneider & Ingram, 2005). Also, people with HIV/AIDS who were well-known or held prominent positions in society shared their stories and were able to normalize the disease through positive portrayals in the media (Epstein, 1996; Kalichman, 1994). In sum, the dissemination of

quantitative and qualitative evidence via research and the media changed public opinion surrounding HIV/AIDS (Kaiser Family Foundation, 2011). The disease was socially reconstructed among policymakers and the public, resulting in increased government allocations and greater access to services for people with HIV/AIDS through more favorable policy designs (Schneider & Ingram, 1997, 2005).

Blueprint for MHMI Advocates

Structural stigma is present in state MHMI legislation across the country, introduced predominantly by males and Republicans. Either policymakers are unaware of the presence of MHMI structural stigma or they have become socially constructed as stigmatized toward people with MHMI conditions. Individuals with a better understanding of mental illness are less likely to endorse stigma (Link & Cullen, 1986). Using HIV/AIDS as a blueprint, social workers should target males and Republicans in power and create anti-stigma campaigns that include partnerships between MHMI researchers and advocates with lived experience to ensure that campaigns are grounded in both science and practice. These partnerships should provide policymakers and the media with (1) quantitative MHMI research evidence demonstrating the presence of structural stigma as well as discrediting stereotypes of dangerousness and fault, and (2) personal, credible stories of individuals with MHMI conditions, especially those currently holding prominent positions in society. The above should aid in the destigmatization and social reconstruction of MHMI, which should reduce the amount of structural stigma in MHMI state legislation.

Implications for the MHMI Policy Process

The findings from research question #2 indicate that the political party of sponsors, the status of their political party in the chamber in which they serve, and structural stigma present in the

language of bills affect whether a MHMI bill passes or fails. Further, MHMI state legislation that was structurally stigmatic in language and introduced by sponsors in majority parties were roughly 2.5 times more likely to pass (Republicans were more likely to get bills passed, but the *p*-value was not significant). These findings provide targets for social workers in their advocacy efforts to prevent stigmatized MHMI legislation from getting passed as well as in their search for sponsorships for favorable MHMI legislation.

Blueprint for Influencing the MHMI Policy Process

The National Association of Social Workers (NASW) Code of Ethics (2008) emphasizes that social workers should be politically active and should advocate for changes in policy and legislation to improve social conditions in order to promote social justice. Political awareness is a prerequisite for practice aimed at changing policy, and in the social work profession, advocacy should not be seen as an option, but rather as an obligation in combating social injustice and ensuring that people are given an equitable chance to meet their basic human needs. Drisko and Maschi (2015) note that social work research needs to follow suit, and social workers should be aware that there is a political aspect to the profession, including in research.

Pritzker and Lane (2013) define political social work as social work research, theory, and practice involving concentrated attention to power dynamics in policymaking as well as political factors for eliciting social change. Political social work consists of the knowledge and skills necessary to affect legislative and policy contexts directly. The main objective of political social work practice is the injection of social work values into the political processes surrounding policymaking. Political social workers contribute to political leadership, lead movements of social change, and empower clients to raise their political voices (Pritzker & Lane, 2013).

To have an effect on the above, advocates must continue their efforts to identify and understand factors that influence key policymaker decisions (Corrigan et al., 2004; Corrigan & Watson, 2003).

A combination of study findings and past literature can be used to provide a blueprint of recommendations for MHMI advocates in their efforts to influence the MHMI policy process (favorable voting and sponsorship).

Who to Target. Social workers should target certain legislators to be policy champions or sponsors. A champion is an individual who is not only willing to support a bill, but is willing to use passion and influence to garner support from colleagues (Brownson et al., 2006). A sponsor leads the charge and introduces the bill to the rest of the legislature. Policy champions may or may not be legislator sponsors, but legislator sponsors should always be policy champions.

Based on findings from the current study, advocates should target Republican policymakers or legislators in the majority parties of the chamber in which they reside (House/Senate). Social workers should target these legislators to advocate against stigmatic policy or to convince them to be policy champions or sponsors for bills. As previously discussed, legislators who are African American, women, and Democrat are more likely to vote in favor of social welfare issues. However, targeting legislators with favorable voting records to influence policy outcomes is only one piece of the puzzle and may only work in parties with Democratic majorities. In order to increase their influence over the MHMI policy process, social workers also need to target Republican legislators who in the current climate, are more likely to be in majority parties and are more likely to get MHMI bills passed as sponsors, regardless of their past voting records.

How to Target. Social workers should insert themselves into the MHMI policy process as soon as possible, as policymakers are increasingly receptive to information from those they are

familiar with and trust (Huntington, 2001). Social workers can cater to Republican legislators specifically by examining the most recent Republican party platform. Republicans historically prefer lower federal government involvement in healthcare, which imposes increased responsibility to the states. For example, in their 2016 federal platform (Committee on Arrangements for the 2016 Republican National Convention, 2016), the Republican party suggested removing the Affordable Care Act and shifting the responsibility of healthcare from the federal government back to the states. The platform mentioned block granting Medicaid as well as returning the responsibility of regulating insurance markets to the states in order to limit federal requirements on private insurance. This plan would cap federal spending and create higher competition for funds at the state level in healthcare, making a mental healthcare advocate's job even more difficult. The Republican healthcare platform suggests that in order to convince Republicans to prioritize mental healthcare, social workers must advocate for MHMI services at the state level that show effectiveness and are fiscally conservative, or show healthy returns on investments (ROIs).

Thus, in their advocacy efforts, social workers should partner with researchers and advocates with lived experience to present evidence-based services (with ROIs attached) to Republicans or legislators in majority parties, in order to influence them in favorable directions. As mentioned earlier, a combination of quantitative and qualitative data presented personally or in the media works best when influencing legislators. One systematic review found that policymakers preferred quantitative research that was relevant and timely to high profile social problems and was delivered personally by the researchers as research briefs (Innvaer et al., 2002). Brownson et al. (2009) suggest evidence-based tips for quantitative public health research dissemination, some of which may also apply to MHMI: data should (1) show a public health burden, (2)

compel policymaker prioritization, (3) show relevance at the voting district (local) level, (4) illustrate potential benefits or harms, (5) personalize an issue, and (6) estimate financial costs with ROIs. In addition to the quantitative and countable, qualitative evidence via narrative dissemination techniques that incorporate personal stories have been demonstrated to cultivate policymaker support (Brownson et al. 2011). Researchers can provide quantitative data and answer key questions to help move the policy agenda in a favorable direction, while advocates with lived experience can share personal stories and assist in communicating research findings during the policy development process.

While research is important, some state legislators view the social problems they prioritize as defined by their constituents (Apollonio & Bero, 2017). Thus, social workers should get the public involved, perhaps through techniques in the media, similar to the MHMI stigma reduction process.

Limitations

The severity of limitations in a research study is relative depending on the research questions and purpose of the study. While the current study attempted to minimize potential limitations during the proposal process, the findings should be viewed alongside caveats in design and methodology.

Limitations of Design

First, the current study's design utilized a single coder to develop the coding scheme and conduct the analysis, which introduced limitations in the trustworthiness of the findings due to the potential for researcher bias or poor intracoder reliability (inconsistency in the application of the codebook) (Maier, 2017; Rose et al., 2015). To curb these limitations and increase trustworthiness, a research journal was maintained throughout the study for transparency. The

journal contained detailed descriptions about difficult coding decisions that were subject to inherent bias or coder inconsistencies. These detailed descriptions were constantly referred to throughout the study to check biases and maintain consistent application of the codebook.

Second, while the search criteria for data collection conceptually defined MHMI based on past research (mental health, mental illness, and psychiatry; Corrigan et al., 2005), other search terms may be more useful moving forward. Specifically, the terms ‘mental health’ and ‘mental illness’ were found in the majority of bills, while the term ‘psychiatry’ was rarely found, and thus, rarely used in sampling or data collection processes. While bills relating to substance abuse were beyond the focus and scope of the current study, terms such as ‘behavioral health’—referring to overall well-being or emotional health, including the prevention and treatment of mental illness and substance use (SAMHSA, 2017)—may be more appropriate than ‘psychiatry’ in capturing a comprehensive sample moving forward.

Third, the effects of structurally stigmatic bills were not created equal; some bills may have had much greater impacts on people with MHMI conditions than others. The current study treated all bills equally and did not measure the magnitude of structurally stigmatic language in bills (multiple times per bill) or rate bills in terms of the magnitude of their potential effect or impact. Future research may wish to measure or rate the potential magnitude of a bill’s negative impact in order to better target the types and topics of bills that may be increasingly stigmatic or harmful toward people with MHMI conditions.

Finally, other variables have been found in the literature to influence legislator voting behavior, but were not able to be captured or utilized in the current study (race/ethnicity, religion, age, education level, geography, ideology, legislative testimony, etc.). Future studies should attempt to operationalize these variables for insertion into the regression model, in order

to gain a more comprehensive look into the relationships between factors of legislative influence, the introduction of structurally stigmatic legislation, and MHMI legislative outcomes.

Limitations of Findings

First, the findings may be limited due to the types of analyses used in the study. For example, chi-square tests of association are sensitive to sample size. With large sample sizes, trivial relationships can appear to be statistically significant, while with smaller sample sizes, the significant relationships may appear weakened. Also, Cramer's V has a tendency to produce lower correlations, even for highly significant results (McHugh, 2013). Finally, regression models reveal relationships between variables, but do not imply causation; a strong relationship between variables in the model could be coming from other, unmeasured variables (Tabachnick & Fidell, 2013).

Second, this study's findings likely underestimate the pervasiveness of MHMI structural stigma. While legislation is critically important to public policy, it is only one type of policy and consequently, only one vehicle for structural stigma. Other written policy initiatives also highly impact people with MHMI conditions, but were beyond the scope of this study, including administrative policies of executive branch agencies (e.g., SAMHSA, HHS) federal and state court decisions, etc. Also, structural stigma may manifest in ways that are unwritten, such as institutional or systemic practices, customs or procedures (Yang et al., 2005).

Third, the findings cannot be generalized to all MHMI legislation as the sample contained only state MHMI legislation and did not include federal bills. This decision was deliberate, as states have great autonomy and power in making decisions that craft their own MHMI systems. However, the federal government sets minimum standards for the states to follow and is a major funding source for state-level mental healthcare. Any structural stigma present in federal MHMI

bills would have the potential to impact states as well as all people with MHMI conditions. This limitation is addressed further below as a topic and target for future research.

Dissemination and Future Research

Dissertation Dissemination

Part of the strategy for social work researchers who engage in policy advocacy is to use their research to motivate or persuade individuals to recognize social problems and respond accordingly (Drisko & Maschi, 2015). When presented with increasing research evidence, policymakers and the public are more likely to recognize and respond to social problems (Mayer, 2009). This strategy will not work without dissemination. As my work has important policy implications and seeks to address one of the 12 Grand Challenges for Social Work (i.e., close gaps in healthcare; Grand Challenges for Social Work, 2020), I hope to rapidly utilize my dissertation work by publishing several manuscripts that employ a mixture of methodologies, including exploring themes, describing trends, and finding predictors.

Qualitative Thematic Analysis

Policy design theory suggests that the content of public policies can contribute to a problem's social construction by introducing highly publicized statements about its causes, effects, and potential solutions (Schneider & Ingram, 1993; Schneider & Sidney, 2009). The social constructions of problems in policy are important, as they often influence public understandings of the problem, in addition to the design of future policy solutions to be considered (Schneider & Ingram, 2005). Thus, using the bill topic and structural stigma variables collected during this dissertation, I plan to disseminate a thematic analysis with aims of exploring how MHMI issues have been socially constructed as problems in state-level bills as well as providing any implications inherent in these constructions. The paper will utilize ethnographic content analysis

(ECA), a kind of thematic analysis that reflexively analyzes textual artifacts and compares concepts across texts to illuminate meaning around a certain phenomenon (Altheide, 1987), such as the collective social constructions of MHMI in legislation.

Policy Mapping Study

The methodology of policy mapping systematically identifies and analyzes policies or policy proposals to capture trends in the use (or nonuse) of policy in addressing specific social problems. Through cataloging policies or proposals, policy mapping studies can identify policy gaps, inform policy agendas, and produce recommendations to researchers for feasible and empirically grounded policy advancement. Policy mapping results are especially useful on topics with limited research surrounding their current policies (Burriss et al., 2010). Purtle and Lewis (2017) note that while mapping studies are often used in areas related to physical health, the methodology has been used sparingly in the mental health field (e.g., Peck and Scheffler 2002; Purtle, 2014; Rowan et al., 2015).

Using the univariate results from this dissertation, I plan to publish a policy mapping paper describing MHMI policy proposals during the Trump administration. The aims of the publication will be to describe the state-level response to MHMI with data already collected, including states and regions where the bills were introduced, bill typologies, target populations (bill topic), and other policy-related variables. Mapping the legislative response to MHMI could identify policy gaps, inform legislator agendas, and assist advocates in their efforts to influence the MHMI policy process.

Quantitative Content Analysis

The bulk of the current study, including its bi- and multivariate results, will be disseminated through publishing a quantitative content analysis (QCA). A QCA codes textual data into

frequencies that can be used in statistical analyses to find patterns and predictors of MHMI voting behavior. The paper will assess the relationship between bill-, sponsor-, and institution-related factors and MHMI state voting outcomes during the Trump administration. Previously analyzed bi- and multivariate results will be reported, with the potential addition of a structural equation model that tests for mediators in the link between structural stigma- language and current bill status. The results will be used to increase public and policymaker awareness regarding the presence of structural stigma in state legislatures as well as to assist advocates during the MHMI policy process.

Strategies for Translational Dissemination

Academic dissemination through the crafting and publishing of dissertation results is important, yet due to the accessibility restrictions of academic journals, the findings may never reach the public. As a result, I plan to disseminate and collaborate with state and local stakeholders (e.g., NAMI) in order to ensure the inclusion of populations that are the most affected by the implications of this dissertation. In my previous experience as a lobbyist, I was exposed to different channels that are suitable for the effective community dissemination of research, including advocacy coalitions, task forces, meetings of professional associations, organizational committees, local and national conferences, etc. Depending on the audience, certain methods of dissemination, such as research briefs, media platforms (news, radio, social media), presentations, training toolkits, legislative testimonies, personal narratives, etc., can be effective in crafting a tailored message for maximum impact.

Future Research

Guided by gaps in the literature and the limitations and findings of this dissertation, I plan to conduct several blocks of studies looking at the policies and policymakers involved in the MHMI

policymaking process, with aims of highlighting structural stigma and building an advocacy toolkit for social workers. Goals include ultimately creating an evidence-based MHMI advocacy intervention for those invested in influencing positive change in the mental healthcare system in order to reduce structural stigma and address gaps in services and access.

Study Block #1: Trends in MHMI Policy

Upon graduation, I'd like to address some of the limitations of this dissertation by further studying MHMI legislation. First, as the current study only examined bills introduced during the Trump administration, I plan to investigate past representations of MHMI legislative proposals during the Obama administrations. Second, as the current study only explored state legislation, I plan to do a thorough examination of federal MHMI bills introduced during both political administrations. Understanding policy trends over time, including similarities and differences between levels of government, political administrations, and past predictors of voting outcomes, could increase the effectiveness of social work macro practice and advocacy efforts related to MHMI issues. In both studies, I intend to incorporate additional predictor variables excluded from this dissertation, such as race/ethnicity, religion, age, geographic region, etc. Finally, as outcome variables, I will continue to examine the current status of bills, but also plan to explore the roll-call votes of legislators. While bill status provides a collective measure of voting outcomes, connecting policymakers to their votes would provide a deeper dive into the nature of their voting behavior.

Study Block #2: Actors in the MHMI Policy Process

Next, as policies are only one piece of the MHMI policymaking process, I plan to shift my focus to the actors involved. Assessing legislator knowledge and attitudes surrounding mental illness is a critical first step to designing strategies that address deficits and misconceptions

(Purtle et al., 2017). First, I will conduct focus groups with local MHMI policy actors, such as Legislative Assistants (LAs), lobbyists, and advocates with lived experience, on what elements of structural stigma are present in the process as well as what factors influence MHMI voting behavior. Their answers will inform the creation of a survey to be administered nationally to LAs, a group that is often ignored in the literature, yet should provide increased response rates and decreased social desirability bias in comparison to the legislators themselves. LAs will act as proxies for their bosses and answer questions surrounding MHMI stigma and factors that influence voting. Results will be used to write several publications with aims similar to previous papers. However, given that I'll potentially have data on a bevy of policymakers and the policies they've designed, I could potentially test policy design theory, exploring pathways linking legislators to their MHMI policies.

Study Block #3: MHMI Evidence-Based Advocacy Intervention

Finally, I plan to integrate my findings related to the policies and policymakers involved in the MHMI policymaking process in order to create new avenues for evidence-based advocacy strategies. As advocacy is integral to the foundations of our profession and affects both policy and practice, interventions should be peer-reviewed and show empirical evidence of effectiveness. Thus, I plan to work with local advocacy organizations to develop and evaluate an evidence-based intervention that can be provided as a training to students, practitioners, and other stakeholders interested in MHMI issues.

Conclusion

For many people with MHMI conditions, access to services and treatment is limited. Legislation is key to closing healthcare gaps, but bills often fail or are introduced with stigmatizing language or restrictions. Social workers are ethically obligated to participate in the

policy process, but increased effectiveness in MHMI advocacy efforts require additional knowledge in the knowledgeable use of influence. The current study examined the nature of structural stigma in MHMI legislative proposals, in addition to factors that influence MHMI outcomes. The study gained valuable insights into the presence and influences of MHMI structural stigma as well potential targets for influencing the MHMI policy process. These findings can be used to bring awareness to those involved in the MHMI policy process on the existence of structural stigma and its effects on bills as well as begin the process of creating blueprints for advocates in their attempts to tailor their advocacy efforts and increase favorable outcomes in addressing mental healthcare gaps across the country.

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Appendix A

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Code Book

Variable

Code (**Recodes**) Item

SPSS Variable Name

Bill-related variables

Bill Topic	TPC01	
	<i>Inductive</i>	

Symbolic	SYM02	
	0	No
	1	Yes

Material-substantive	SUB03	
	0	No
	1	Yes

Material-procedural	PRO04	
	0	No
	1	Yes

Status	STA05	
	0	Fail
	1	Pass

Reduces Personal Liberties	RPL06	
	0	No
	1	Yes

Reduces Protections Against Discrimination		RPAD07
	0	No
	1	Yes

Reduces Privacy		RPRV08
	0	No
	1	Yes

Reduces Resources and Services		RRS09
	0	No
	1	Yes

Structural Stigma: Potential Effect		SSPE10
	0	No
	1 → 1	Reduces personal liberties
	2 → 1	Reduces protections against discrimination
	3 → 1	Reduces privacy
1=Yes	4 → 1	Reduces resources and services

Labeling		SSL11
	0	No
	1	Yes

Stereotyping		SSST12
	0	No
	1	Yes

Separating		SSS13
	0	No
	1	Yes

Status Loss		SSSL14
	0	No
	1	Yes

Discrimination		SSD15
	0	No
	1	Yes

Structural Stigma: Language		SSL16
	0	No
	1 → 1	Labeling
	2 → 1	Stereotyping
	3 → 1	Separating
	4 → 1	Status Loss
	5 → 1	Discrimination
3-5=Yes	0 → 5	Total

Sponsor-related variables

Majority Gender		MGDR17
	0	Female
	1 → 1	Male
	2 → 1	Split
1=Male	3 → 1	Committee

Majority Political Party		MPP18
	0	Republican
	1 → 1	Democrat
	2 → 1	Split
	3 → 1	Committee
1=Dem	4 → 1	Nonpartisan

Political Party Maj/Min Status		PPS19
	0	Minority
	1 → 1	Majority
	2 → 1	Split
1=Maj	3 → 1	Other

Institution-related variables

Chamber		CHMBR20
	0	Lower (House of Representatives)
	1	Higher (Senate)