Newtown, Parkland, and Uvalde: Why (Some) Mass Shootings Transform Community Mental Health

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
(Health Services Organization and Policy and Political Science)
in the University of Michigan
2023

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Dedication

To Mel Herrin – without you, none of this is possible.

Acknowledgements

Researching and writing a dissertation is a daunting and vulnerable experience. I benefitted enormously from the thoughtfulness, kindness, and patience of mentors, friends, and family who always made me feel, even when I didn't, that I had something worthwhile to say.

First and foremost, I thank my advisors and dissertation committee chairs: Holly Jarman and Charles Shipan. Holly and Chuck are exceptional mentors and advocates, supporting my development as a political scientist and health policy researcher in and beyond the classroom, research, and administrative settings. They have always expressed their belief in my abilities as a researcher, regularly made my work better, and motivated me to keep going. Words cannot express my gratitude. I am incredibly thankful for the mentorship of Scott Greer, who never accepted anything less than my best work and provided valuable insights to help me achieve this potential. Rob Mickey provided guidance from the moment I joined the political science department and vital insights about the politics of community health.

During the past six years as a doctoral student, I have benefitted tremendously from other faculty at the University of Michigan. I am immensely indebted to Kyle Grazier's unwavering support for my research at the Behavioral Health Workforce Research Center (BHWRC), which led me to my dissertation topic. I thank the other members of the BHWRC, who created an unparalleled working environment. They include Angela Beck, Jessica Buche, Maria Gaiser, Cory Page, Simone Singh, Victoria Schoebel, and Caitlyn Wayment. Rebecca Haffajee and Julia Wolfstein took me under their wings during my first year as a doctoral student, including me on

research projects that would shape my interests to this day. I especially want to thank Melissa Creary and Katherine Hendy for including me in research that I believe has the potential to be immensely impactful. I look forward to growing this collaboration. I could not have asked for a better research assistant than Skyler Edinburg: an undergraduate student at the University of Michigan who demonstrates the meticulousness, consistency, and entrepreneurialship of a professional researcher. None of my success would be possible without the dedication of the University of Michigan School of Public Health staff, including Keith Arthur, Brenda Bernhardsson, Josephine Li, Amy Taylor, Kaitlin Taylor, and Jessica Whipple. Thank you.

I entered the University of Michigan expecting to identify brilliant collaborators and mentors but was unprepared to find such close friends. I look back fondly at my classes with Maria Carabello, Jason Gibbons, and Emily Lawton and look forward to running into each other in the future. Anton Avanceña, Ellen Kim DeLuca, Landon Hughes, Kasia Klasa, and Brad Iott remain exceptional colleagues and indispensable friends. Our office remains my favorite workspace to date. I met Phil Singer and Charley Willison at Angelo's on visit day. From that moment, they have been more generous with their time and knowledge than I ever deserved. Thank you to my political science colleagues, Michelle Falkenbach, Karolyn Kiessling, N'dea Moore-Petinak, Sarah Rozenblum, and Emma Willoughby. I remain nostalgic about my years in Ann Arbor because of you.

Most importantly, I thank my family. My brother, Daniel Mauri, is a constant source of inspiration, tenacity, and friendship. My mom, Dena Herrin, is my model for strength, determination, and hard work. My dad, Alfredo Mauri, is one of my closest friends and my favorite brainstorming partner. Thank you, Danny, Mom, and Dad, for your encouragement, support, and love.

And to Pieter, my partner and husband. I cannot adequately express my gratitude for his gentle push when I feel unmotivated; ovation when I have the most minor success; and silent, active support at all other times. Thank you for being my soundboard, helping me develop ideas and always encouraging me to think from different perspectives. I cannot wait for our future.

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Abstract

Some of the most horrific tragedies in the past 15 years transformed federal community mental health policy. On December 14, 2012, a shooter killed 26 people at Sandy Hook Elementary School in Newtown, Connecticut, and on May 22, 2022, a shooter murdered 21 people at Robb Elementary School in Uvalde, Texas. Newtown led to Congress adopting a bill that ruptured three decades of community mental health policy impasse. Uvalde resulted in a law that substantially expanded the program created after Newtown. But this policymaking process was a long time coming. Legislators introduced each bill over 10 times before enactment after Newtown and Uvalde. What happened between these mass shootings and policy adoption that led political actors to awaken the paralyzed policy area of community mental health policy?

The Newtown and Uvalde shootings increased the likelihood of adopting community mental health legislation by motivating political actors to adapt existing bills to become the perceived solution to a problem prioritized by each event: mental illness allegedly causing violence. I build on existing research examining this coupling process by explaining adaptation granularly. Newtown and Uvalde incentivized political actors to make two adaptations to existing legislation. First, each mass shooting motivated politicians to adapt their rhetoric describing the bill and policy entrepreneurs to modify the legislation's design. These adaptations attached the bills to the problem garnering attention, and this link carried the bills through the legislative process toward enactment.

However, political actors did not modify or adopt related community mental health bills after a similar incident on February 14, 2018 in Parkland, Florida, where a shooter killed 17 people at Marjory Stoneman Douglas High School. Understanding what happened after Newtown, Parkland, and Uvalde will be crucial to explaining why some mass shootings lead political actors to adapt and adopt community mental health policy reforms.

I employ a most similar systems design that compares akin cases except for the studied phenomenon. Newtown, Parkland, and Uvalde share many features. A male pupil murdered students and staff at his former school. Each shooting heightened attention to the problem of mental illness allegedly causing violence, creating an incentive to adapt existing policies to become the solution to this issue. Lawmakers had introduced related community mental health bills only months before each shooting. And a bipartisan coalition led by the same four lawmakers sponsored the bills. Why did Newtown and Uvalde catalyze the adaptation of these bills, contributing to their enactment, while Parkland did not?

Lawmakers who possess control over the legislative agenda, which I call agenda setters, are crucial to answering this question. Agenda setters have immense influence over which bills progress through the legislative process and which stagnate in committee. Political actors only engaged in the adaptation process if they judged that agenda setters would not use these controls to prevent the modified bill from progressing through the legislative process. Following Newtown and Uvalde, relevant agenda setters – some Democratic and some Republican – supported the community mental health bills, signaling that their agenda controls would not act as an impediment. Lawmakers occupying these agenda setting positions at the time of Parkland did not offer this support. Together, this research shows that agenda setter support was a

necessary condition for political actors to adapt and adopt community mental health policy after a mass shooting.

Chapter 1 Introduction

A mass shooting at an elementary school in Uvalde, Texas supposedly reversed a "decades-long impasse on gun safety" (Karni and Cochrane 2022). A shooter murdered 19 10- and 11-year-old students and two teachers at Robb Elementary School on May 24, 2022. A month later, Congress passed the Bipartisan Safer Communities Act, which contained a package of gun safety and mental health service reforms. People from across the political spectrum described this policy as landmark legislation. *The Wall Street Journal* wrote that lawmakers achieved a "breakthrough on gun-control legislation" (Andrews and Collins 2022). *The Los Angeles Times* proclaimed that President Biden on Saturday signed the most wide-ranging gun violence bill in decades (Fram 2022).

But was the Bipartisan Safer Communities Act really such a breakthrough? While the bill's enactment diverged from a history of federal paralysis in gun policy, in other ways, the policy outcome after Uvalde mirrored that following another abhorrent event. On December 14, 2012, a gunman killed 20 six and seven year old students and six teachers at Sandy Hook Elementary School in Newtown, Connecticut.[1] Both the 2012 Newtown and 2022 Uvalde school shootings dramatically expanded federal involvement in community mental health centers.

Community mental health centers are critical safety net providers of behavioral health services. They provide outpatient, emergency, and other mental services to patients regardless of

[1] While the shooting in Newtown, Connecticut is often discussed using the name of the elementary school – Sandy Hook – where the shooting occurred, I elect to call it Newtown in alignment with the names commonly used for the other two mass shootings – Parkland and Uvalde – discussed in this dissertation.

their ability to pay. In 1981, Congress replaced a national community mental health centers program with a block grant, severely reducing the federal financial contribution to the over 800 community mental health centers covering 50% of the U.S. population at the time (Foley and Sharfstein 1983, 263). The 2012 Newtown school shooting catalyzed a policymaking process that led to the adoption of a bill that reversed this 30 year legacy of limited federal involvement in community mental health care, and the 2022 Uvalde mass shooting resulted in a law that substantially expanded the program created after Newtown.

What happened between these mass shootings and policy enactment that led to the adoption of transformational community mental health policy reforms? The Newtown and Uvalde shootings increased the likelihood of adopting community mental health legislation by motivating political actors to adapt existing bills so that they became the perceived solution to a problem prioritized by each event: mental illness allegedly causing violence. Put another way, the shootings provided a problem that political actors hooked to their bill through rhetorical and design adaptations, regardless of if the legislation actually solved the problems responsible for each event. Following these modifications, the problem of the perceived relationship between mental illness and violence carried the community mental health bill through the legislative process toward enactment.

Specifically, the shooting at Sandy Hook Elementary School in Newtown, Connecticut incentivized lawmakers to adapt the Excellence in Mental Health Act, which legislators previously introduced 12 times in three Congresses before finally enacting the bill. The legislation created a new type of community mental health provider, certified community behavioral health centers (CCBHCs), and a program to financially support the establishment and maintenance of the CCBHC program. Following Newtown, political actors changed how they

talked about this bill, newly describing the proposal using violence rhetoric that claimed the policy would prevent another school mass shooting and modified the design of the legislation to accommodate new political interest in the problem of mental illness allegedly causing violence. These adaptations were essential to the policymaking process that led to the adoption of the Excellence in Mental Health Act, which represented the most expansive reforms to community mental health policy in 30 years.

Political actors adapted a related community mental health bill after Uvalde. Before the shooting at Robb Elementary School in Uvalde, Texas, lawmakers had attempted to expand the CCBHC program created after Newtown 10 times in four Congresses. Uvalde motivated political actors to adapt this legislation – the Excellence in Mental Health and Addiction Treatment Expansion Act – to align with the problem of the perceived relationship between mental illness and violence. Following Uvalde, political actors used more violence rhetoric when describing the bill and modified the legislation's design to reflect the politicians, and their ideological and partisan preferences, that became newly interested in the problem after the shooting. This adaptation process led lawmakers to pass the modified version of the Excellence in Mental Health and Addiction Treatment Expansion Act, which expanded the original CCBHC program by adding 10 states every two years to the program.

Together, these reforms have contributed to the expansion of the CCBHC program from 67 clinics in eight states in 2017, when the program created after the Newtown bill was implemented, to over 500 clinics operating in 46 states, Puerto Rico, Washington D.C., and Guam today. The total federal funds to CCBHC initiatives nears $3 billion. Politicians and community mental health providers describe the CCBHC program as revolutionizing community mental health. In describing the Excellence in Mental Health Act, adopted after Newtown,

Senator Blunt (R-MO) stated that the law "was the biggest step forward in expanding community mental health and addiction services in decades" (Blunt 2021). Linda Rosenberg, the former President and CEO of the National Council for Mental Wellbeing, an advocacy group representing mental health and substance use treatment organizations, affirmed: "the Excellence in Mental Health Act is the biggest federal investment in behavioral health care in over 40 years" (Stabenow 2015). In describing the Excellence in Mental Health and Addiction Treatment Expansion Act, passed after Uvalde, Senator Stabenow (D-MI) wrote, "this bill builds on my transformational behavioral health care initiative to bring high-quality mental health and addiction services to communities across the country to get people the care they need as part of the health care system" (Stabenow 2022a). And Brent McGinty, President and CEO of the Missouri Coalition for Community Behavioral Healthcare, claimed that the bill would "transform behavioral health care in this country, driving a fragmented and underfunded system to one with expanded access to evidence-based treatments, integrated healthcare, and accountability" (Blunt 2016). The community mental health bills adopted after the Newtown and Uvalde shootings represented substantial deviations from existing community mental health policy.

However, not all school mass shootings triggered a policymaking process whereby political actors adapted existing community mental health legislation to align with the problem of mental illness allegedly causing violence, increasing the likelihood that these bills would become law. On February 14, 2018, a shooter killed 17 people and injured 17 others at Marjory Stoneman Douglas High School in Parkland, Florida. Unlike the shootings in Newtown and Uvalde, lawmakers did not adapt or adopt community mental health legislation after Parkland. This is particularly surprising given that the Parkland shooting shares many similarities with Newtown and Uvalde. First, the perpetrators of all three shootings were male former students.

Second, all three events heightened public and political interest in the perceived relationship between mental illness and violence. Finally, before or immediately after all three shootings, a bipartisan group of lawmakers supported legislation that created or expanded the CCBHC program.

Understanding what happened after the school shootings in Newtown, Parkland, and Uvalde will be crucial to explaining why some school mass shootings catalyzed the adaptation of transformational community mental health bills to align with the problem of mental illness allegedly causing violence, ultimately leading to the adoption of these reforms, while others have not impacted the adaptation or adoption of community mental health policy.

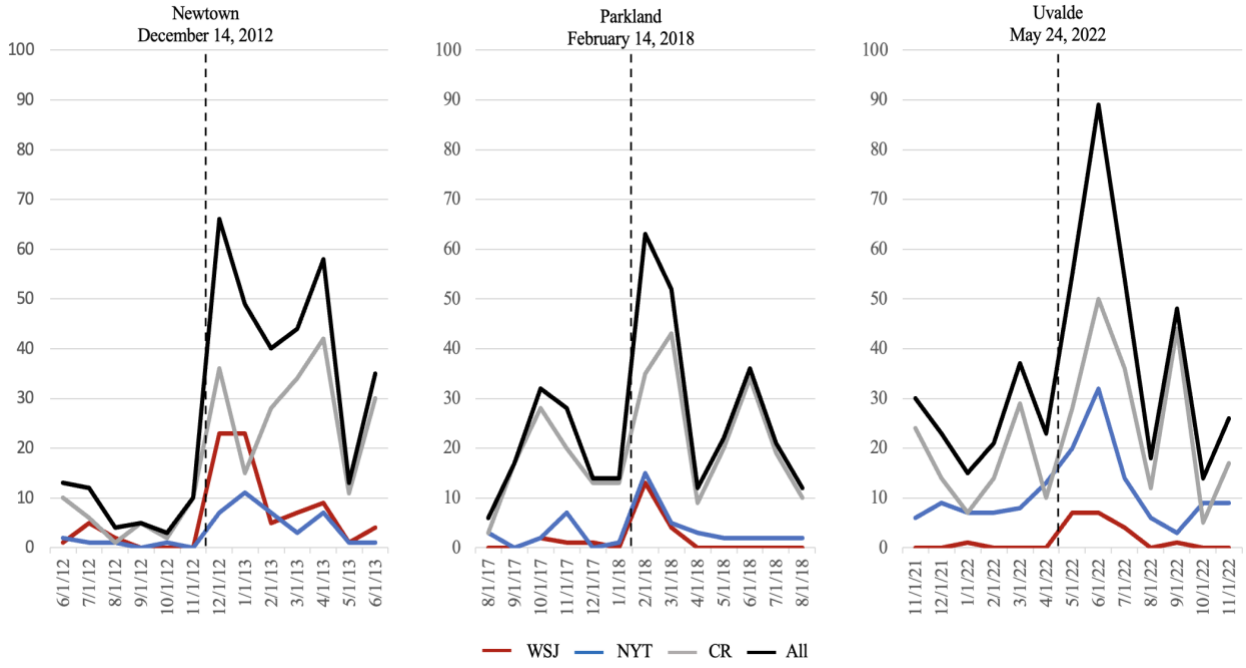
1.1 The Perceived Relationship Between Mental Illness and Violence

A critical aspect of each mass shooting is that all three events rapidly and sharply increased attention to the same problem: mental illness allegedly causing violence. Prior to documenting this heightened attention, I pause to emphasize that the relationship between mental illness and violence is, at best, tenuous (Metzl and MacLeish 2015; Metzl, Piemonte, and McKay 2021). The vast majority of persons with serious mental illness are not violent (Elbogen and Johnson 2009; Fazel et al. 2009), and a very small proportion of gun violence perpetrators involve a person with a serious mental illness (Burris et al. 2010; McGinty et al. 2014). Thus, in this dissertation, I always discuss the relationship between mental illness and violence as alleged; no evidence demonstrates that persons with a serious mental illness are substantially more likely to commit acts of violence than individuals without these disorders.

Despite this weak relationship between mental illness and violence, school shootings in Newtown, Parkland, and Uvalde turned public and political attention to this perceived problem. Figure 1.1 demonstrates that the volume of newspaper articles and Congressional Record

statements containing references to both mental illness and violence substantially increased after each shooting. For instance, a month after the Newtown shooting in December 2012, *The New York Times* released an article titled: "New York Has Gun Deal, With Focus on Mental Ills" (Kaplan and Hakim 2013). After the Parkland shooting in February 2018, House Speaker Paul Ryan (R-WI) stated that "lawmakers 'probably have to do a better job,' making sure mentally ill Americans don't have access to guns" (Bender and Bykowicz 2018). And following the school shooting in Uvalde in May 2022, President Biden called on Congress to "address the mental health crisis" in addition to gun safety reforms, such as safe storage and red flag laws (Shear 2022).

Figure 1.1: Newspaper Articles and Congressional Record Statements Containing References to "Mental Illness" and "Violence"



Note: WSJ: Wall Street Journal. NYT: New York Times. CR: Congressional Record. I identified news articles using the following search strategy. In The New York Times and The Wall Street Journal Databases in ProQuest News & Current Events, I searched the following text string: ("mental illness" OR "mental health") AND ("violence" OR "violent" OR "gun" OR "shooting"). I limited the search to anywhere in the article except the full text, meaning that the search included the title, abstract, subject, and other summary. I further limited the search by excluding articles with a source type other than "Newspaper" and articles not written in English. I identified statements in the Congressional Record by searching the same text string in the Congressional Record search of congress.gov.

These discussions sometimes explicitly blame mental illness as the culprit of violence. Following the shooting in Uvalde, Senator Blunt (R-MO) claimed that "making sure people who are experiencing a mental health crisis can get treatment before they harm themselves or others is critically important to preventing another tragedy" (Stabenow 2022b). After Newtown, Senator Blumenthal (D-CT) stated when introducing mental health legislation that "gunmen responsible for mass shootings highlight how mental illness can cause carnage and killing… we need to identify and treat people suffering from mental illness before they damage or destroy other lives" (Bennet 2013). Other times discussions of gun policy reforms mention mental illness, implicitly implying a link between violence and mental illness: "Senate bargainers on Sunday announced the framework of a bipartisan response to last month's mass shootings, a noteworthy but limited breakthrough offering modest gun curbs and stepped-up efforts to improve school safety and mental health programs" (Murphy 2022b). Even discussions that aim to point out that blaming mental illness as the culprit of violence distract from the real problem of firearm accessibility nonetheless bring attention to this false link. For instance, after the Uvalde shooting, Chris Murphy (D-CT) adamantly declared, "spare me the bullshit about mental illness" (Gregorian 2022). However, just calling attention to this alleged link may cause people to consider whether there is a relationship between mental illness and mass shootings.

Events like these school shootings that rapidly increase attention to a problem are often called *focusing events*.[2] While other events may heighten attention to a problem, focusing events are distinct in that they raise attention so much that the problem becomes a priority. For instance, the September 11, 2001 terrorist attacks are a clear example of a focusing event. Other events that abruptly and substantially heightened attention to a problem include Hurricane Katrina and

[2] I introduced this term here and describe it in more detail in Chapter 2.

the 2008 Global Financial Crisis. At the same time, other events may increase attention but are not focusing because they do not dominate public and political attention. Birkland and Schwaeble (2019) distinguish focusing events from other events using the volume of media coverage following terrorist attacks. The substantial media attention following the 2015 terrorist attacks in Paris compared to the lesser volume following attacks that same year in Lebanon, Kenya, and Nigeria suggests that the Paris attack was a focusing event. The other terrorist attacks, on the other hand, may have increased attention to the problem of terrorism but not to the point where it became a priority concern.

The mass shootings in Newtown, Parkland, and Uvalde undoubtedly meet this definition of a focusing event. Regardless of whether the mass shooting's cause was accurately identified, each event rapidly increased attention to the problem of mental illness allegedly causing violence, so it became a priority issue. Following sections provides an in-depth description of why these focusing events, through heightening attention to the problem of the perceived link between mental illness and violence, increased the likelihood of adopting substantial community mental health policy reforms.

1.2 Community Mental Health Centers

But what are community mental health centers? Before discussing my argument for why mass shootings incentivized policymaking related to community mental health, this section provides a brief overview of this mental health provider. Community mental health centers are a lynchpin within the mental health care safety net. Community mental health centers that participate in the Medicare Program and/or receive funds through the federal Community Mental Health Services Block Grant are required to offer outpatient, emergency, day treatment, and screening services to individuals. The Medicare program also requires that community mental

health centers provide at least 40 percent of its services to individuals not eligible for Medicare (Centers for Medicare & Medicaid Services 2013; Texas Health and Human Services 2023), and the Block Grant requires that centers provide services principally to individuals residing in a defined geographic area and, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services (Substance Abuse and Mental Health Services Administration 2014).

Besides these federal criteria, community mental health centers, vary substantially in other ways. Federal criteria defining community mental health centers devolve certification authority to state entities and provide states substantial latitude to impose additional community mental health criteria. [3] Consequently, centers differ in the specific services offered, populations served, and providers employed, as well as their primary funding streams. Indeed, while Medicaid is an important funding source, Medicaid payment rates have not historically covered the full cost of care, leading community mental health centers to rely on a patchwork of state, local, and philanthropic funding to cover the costs of Medicaid beneficiaries and patients without insurance and potentially contributing to substantial differences in community mental health care access and provision across communities (Cummings et al. 2017, 2021; Hung et al. 2020; Newton et al. 2022; Presnall, Butler, and Grucza 2022; Shim et al. 2015).

This variability primarily resulted from the 1981 transition from a national community mental health centers program to a block grant. Federal legislative involvement in community mental health care began in the 1960s. Between 1963 and 1981, Congress established and maintained a national community mental health centers program. While the specific service

[3] The Secretary of Health and Human Services directs state health agencies or other appropriate agencies to determine whether an organization meets the federal Medicare standards through the helping function termed "provider certification." The Community Mental Health Services Block Grant limits states when they select recipients of the grant to community programs, including community mental health centers.

criteria defining community mental health centers evolved during this period, the national program provided categorical grants to states and clinics to support construction, staffing, and service costs. While the program never fulfilled its intent of creating 2,000 centers by 1980, it funded approximately 800 centers by this year, covering over 50.0% of the US population or 115 million people (Foley and Sharfstein 1983, 263), and laying the foundation for today's infrastructure of community mental health providers.

In 1981, Congress mostly repealed the laws containing the national community mental health center program and replaced them with a block grant, creating the origin of today's Community Mental Health Services Block Grant. This Block Grant offers states a lump sum award to support the provision of mental health services in community settings, which states then distribute to community mental health providers (Substance Abuse and Mental Health Services Administration 2014). Between 1981 and 2014, the Community Mental Health Services Block Grant remained the primary categorical mechanism by which the federal government supported community mental health services. Several authors have documented the resulting transformation in community mental health care, including the increasing variability in the characteristics of community mental health centers and reliance on Medicaid, even though these payments often do not cover full care costs (Estes and Wood 1984; G. N. Grob 2016; Ray and Finley 1994; Sharfstein and Wolfe 1978).

The December 2012 Newtown shooting catalyzed a policymaking process that attempted to standardize some of this variability and address the shortcomings of Medicaid payment for community mental health services. The 2014 Excellence in Mental Health Act – embedded within Section 223 of the Protecting Access to Medicare Act – established a new community mental health provider – CCBHCs – and a Medicaid Demonstration that created a new way of

paying for services delivered by CCBHCs. CCBHCs must provide nine categories of services to patients regardless of residency or ability to pay. These services include outpatient mental health and substance use, crisis mental health care, screening, and peer support. CCBHCs must also coordinate their care with five groups of medical and social service providers: federally qualified health centers; inpatient psychiatric and substance use detoxification and residential treatment facilities; Department of Veterans Affairs medical facilities; hospital outpatient clinics and acute care departments; and other community and regional supports, like schools, criminal legal institutions, and child placing agencies. In addition, CCBHCs must ensure the availability and accessibility of services by, for instance, employing staff that are diverse and culturally and linguistically appropriate for the client population.

CCBHCs participating in the Medicaid Demonstration receive a new Medicaid prospective payment calculated to cover the full cost of CCBHC care. Specifically, states reimburse CCBHCs using a daily or monthly predetermined, fixed rate for each day or month that a Medicaid patient receives care (Brown et al. 2023). The rate does not vary by the services delivered, the providers involved, or a patient's diagnosis. The goal of the reimbursement mechanism is to provide CCBHCs flexibility in care delivery without financial concern at the encounter level (Substance Abuse and Mental Health Services Administration 2016, 2023b). In December 2016, the Department of Health and Human Services (HHS) selected Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania to participate in the original two-year CCBHC Medicaid Demonstration (Office of the Assistant Secretary for Planning and Evaluation 2019, 2020), though Pennsylvania left the Demonstration in 2019 and Minnesota left in 2022 (Kelly and Brykman 2023). The May 2022 Uvalde shooting initiated a series of policy activities that resulted in the most significant expansion of the CCBHC Medicaid

Demonstration since its enactment. The 2022 Excellence in Mental Health and Addiction Treatment Expansion Act – embedded within the Bipartisan Safer Communities Act – extended the original Demonstration program through September 30, 2025 and authorized the addition of 10 states every two years beginning in July 2024 until the program is nationwide.[4]

The CCBHC program has grown in other ways beyond the Medicaid Demonstration. Congress allocated funds for the CCBHC Expansion Grant program, where the Substance Abuse and Mental Health Services Administration awards clinics that meet or will meet the 2014 CCBHC criteria grants to support direct service and infrastructure costs. Importantly, clinics participating in the Expansion Grant program do not receive the special Medicaid payment rate associated with the CCBHC Medicaid Demonstration. In addition, seven states – Kansas, Minnesota, Missouri, Nevada, Oklahoma, Pennsylvania, and Texas – have adopted legislation and used Medicaid flexibilities, such as state plan amendments and waivers, to create their own special Medicaid payment for CCBHCs.

In 2021, the 361 active CCBHCs represented a substantial share of the 2,218 community mental health clinics serving more than 700,000 patients (Substance Abuse and Mental Health Services Administration 2023a). This proportion has undoubtedly grown as the total number of CCBHCs has increased to 493 clinics operating in 46 states, Puerto Rico, and Washington D.C today. In total, Congress has appropriated over $3,000,000,000 to CCBHC programs with this amount increasing when the Center for Medicare and Medicaid Services implements the CCBHC Medicaid Demonstration in the states added because of the 2022 law. In sum, the CCBHC

[4] Between the passage of the Excellence in Mental Health Act in 2014 and the adoption Excellence in Mental Health and Addiction Treatment Expansion Act in 2022, Congress adopted several smaller extensions and expansions of the CCBHC Medicaid Demonstration. For instance, the original Demonstration was scheduled to end on July 1st, 2019, but several extensions prolonged the program until the 2022 bill extended it through September 30, 2025. In 2020, HHS added Kentucky and Michigan to the Demonstration. However, none of these extensions or expansions neared the significance of that contained within the 2022 law.

Medicaid program – established and expanded by policymaking activities catalyzed by shootings in Newtown, Connecticut and Uvalde, Texas – represent important reforms to federal community mental health policy.

1.3 Mass Shootings, Community Mental Health Policy, and Coupling

The Newtown, Parkland, and Uvalde mass shootings examined in this dissertation enhanced the probability of adopting the 2014 and 2022 bills related to the CCBHC Medicaid Demonstration discussed in the previous section. Six months before the shooting in Newtown, legislators had introduced the Excellence in Mental Health Act, and four months before Parkland and two months before Uvalde, lawmakers had introduced the Excellence in Mental Health and Addiction Treatment Expansion Act. The three focusing events motivated political actors to adapt these existing community mental health policy proposals to align with the problem prioritized after each shooting – mental illness allegedly causing violence – increasing the likelihood that the proposals would progress through the legislative process.

Politicians are more likely to act on a proposal that solves a problem capturing attention. The shootings in Newtown, Parkland, and Uvalde heightened attention to the problem of mental illness allegedly causing violence. Consequently, all three focusing events incentivized political actors to adapt existing community mental health policy proposals to align with this problem, so that the proposal was more likely to become a legislative priority. Adaptation may occur through rhetoric, for instance, politicians may newly talk about the community mental health policy as key to preventing another school shooting. Or they may adapt a proposal through design, such as by changing provisions within the policy to accommodate groups that became newly interested in the problem after the mass shooting. Regardless of the specific mechanism, the shootings in Newtown, Parkland, and Uvalde increased the likelihood that political actors would engage in

community mental health proposal adaptation because they provided a problem to carry the proposal through the legislative process.

This process is called *coupling*.[5] Described in John Kingdon's *Agendas, Alternatives, and Public Policy* (1984), political actors achieve coupling when they adapt a policy proposal so that it becomes the perceived solution to a problem in a way that is amenable to the political environment (178). In the cases used in this dissertation, coupling occurred when political actors adapted existing community mental health policy proposals to align with the increase in attention to the problem of mental illness allegedly causing violence after each school shooting.

But how does coupling happen? What are the mechanisms involved in the coupling process after a focusing event like the Newtown, Parkland, and Uvalde shootings? Most accounts of coupling, including Kingdon's own, fail to provide a granular examination of the range of strategies involved in proposal adaptation. This is problematic because political actors have choices in adapting a policy proposal to align with the problem capturing attention after a focusing event. They may change a proposal's design, the rhetoric used to describe the proposal, or some combination. I offer this nuanced investigation into the mechanisms involved in coupling to identify which mass shootings resulted in the coupling of existing community mental health policy proposals, and which did not impact proposal adaptation.

I argue that the Newtown, Parkland, and Uvalde shootings motivated political actors to engage in two coupling processes. First, each mass shooting incentivized politicians to adapt policy proposal rhetoric in response to increased public attention to the problem of mental illness allegedly causing violence, so that the proposal became the perceived solution to the problem. Second, the mass shootings also incentivized policy entrepreneurs – the people around

[5] I introduce this term here and define it more detail in Chapter 2.

government who generate, design, and write legislation – to adapt policy proposal design in response to heightened political attention to the problem of the perceived relationship between mental illness and violence. This design adaptation accommodated the public policy preferences of the politicians newly attentive to the problem after the mass shooting. Through these two adaptations, political actors increased the probability of coupling the existing community mental health policy proposal with the problem prioritized after each mass shooting, likely placing the proposal at the top of the legislative agenda.

1.4 More Than Shooting Profile, Policy, and Partisanship

But coupling does not necessarily follow a focusing event. Indeed, the three mass shootings examined in this dissertation offer two cases where political actors engaged in the coupling of community mental health policy proposals after a mass shooting, and one case where no proposal adaptation occurred. The Newtown and Uvalde mass shootings offer examples where political actors achieved coupling; politicians and policy entrepreneurs adapted community mental health proposal rhetoric and design in response to the mass shooting, raising attention to the problem of mental illness allegedly causing violence, contributing to the adoption of two major reforms to community mental health policy: the Excellence in Mental Health Act in 2014 and the Excellence in Mental Health and Addiction Treatment Expansion Act in 2022. In contrast, Parkland provides an example of a focusing event that did not trigger the coupling of similar community mental health proposals to those available at the time of Newtown and Uvalde. After the Parkland school shooting, political actors did not adapt proposal rhetoric or design in response to the heightened attention to the perceived link between mental illness and violence. This leads us to the fundamental question of my dissertation: despite the same incentives to adapt proposals to align with the problem garnering attention after each school

shooting, why did the Newtown and Uvalde focusing events catalyze the coupling process, but Parkland did not?

Several factors might explain this difference in coupling or proposal adaptation. I refute some of these potential explanations in Table 1.1 under alternative explanations and in the following paragraphs. First, maybe there is something distinct about the profile of the school shootings in Newtown and Uvalde versus Parkland that led political actors to engage or not engage in coupling. But the three shootings have remarkably similar profiles. All three shootings were mass casualty events occurring in school settings where the perpetrator was a male former student. The only potential difference is that the shootings in Newtown and Uvalde took place at elementary schools with victims below the age of 12, whereas the Parkland shooter killed students and staff at a high school. However, this difference in setting likely does not explain the coupling outcome since each shooting substantially raised public and political attention to the problem of mental illness allegedly causing violence.

Second, perhaps there was something unique about the community mental health policy proposal available for adaptation at the time of Parkland compared to Newtown and Uvalde. Indeed, it is possible that features of the policy explain why political actors engaged in proposal adaptation after some shootings but not others. However, at the time of each school shooting, lawmakers had expressed support for nearly identical significant community mental health policy proposals. Six months before the shooting in Newtown, legislators had introduced the Excellence in Mental Health Act, which created a new community mental health provider, CCBHCs, and a new program to financially support the establishment and maintenance of the CCBHC program. Four months before Parkland and two months before Uvalde, lawmakers had introduced the Excellence in Mental Health and Addiction Treatment Expansion Act, which

expanded the reach of the CCBHC program by adding more locations and extending the program's expiration date. Thus, at the time of each school shooting, political actors had very similar community mental health policy proposals available for adaptation, implying that features of the policy itself likely do not explain why political actors engaged in coupling these policies after Newtown and Uvalde, but not after Parkland.

Table 1.1: Potential Explanations for Coupling After Mass Shooting

	December 14, 2012: Newtown, CT	**February 14, 2018: Parkland, FL**	**May 24, 2022: Uvalde, TX**
Coupling			
Rhetoric adapted	Yes	No	Yes
Design adapted	Yes	No	Yes
Coupling	Yes	No	Yes
Potential explanations			
Shooting profile	Elementary school 26 individuals killed Shooter: Male, former student	High school 17 individuals killed Shooter: Male, former student	Elementary school 21 individuals killed Shooter: Male, former student
Community mental health policy	Excellence in Mental Health Act	Excellence in Mental Health and Addiction Treatment Expansion Act	Excellence in Mental Health and Addiction Treatment Expansion Act
Bipartisan sponsors	Yes	Yes	Yes
Gun agenda	Yes	Yes	Yes
Seats			
House	House: *234 R*, 201 D	House: *241 R*, 194 D	House: *222 D*, 212 R
Senate	Senate: *53 D*, 45 R, 2 I	Senate: *51 R*, 47 D, 2 I	Senate: *48 D*, 50 R, 2 I
Explanation			
Agenda setter support			
House	Yes	No	Yes
Senate	Yes	No	Yes

Note: R = Republican; D = Democrat. Italicized is the party in control. I operationalize seats as the partisan distribution within each chamber. I define gun agenda as periods when gun control is at the top of the legislative agenda. I define leader support as community mental health policy support from an agenda setter, which I define in later sections. For Newtown, I report the bipartisan sponsors, house seats, senate seats, and leader support for the 113th Congress, even though Newtown occurred at the very end of the 112th Congress. This is because the far majority of the coupling process happened during the 113th Congress, which was sworn in less than a month after Newtown.

Political actors may have coupled another mental health policy with the problem capturing attention after Parkland. Put another way, political actors may have selected an

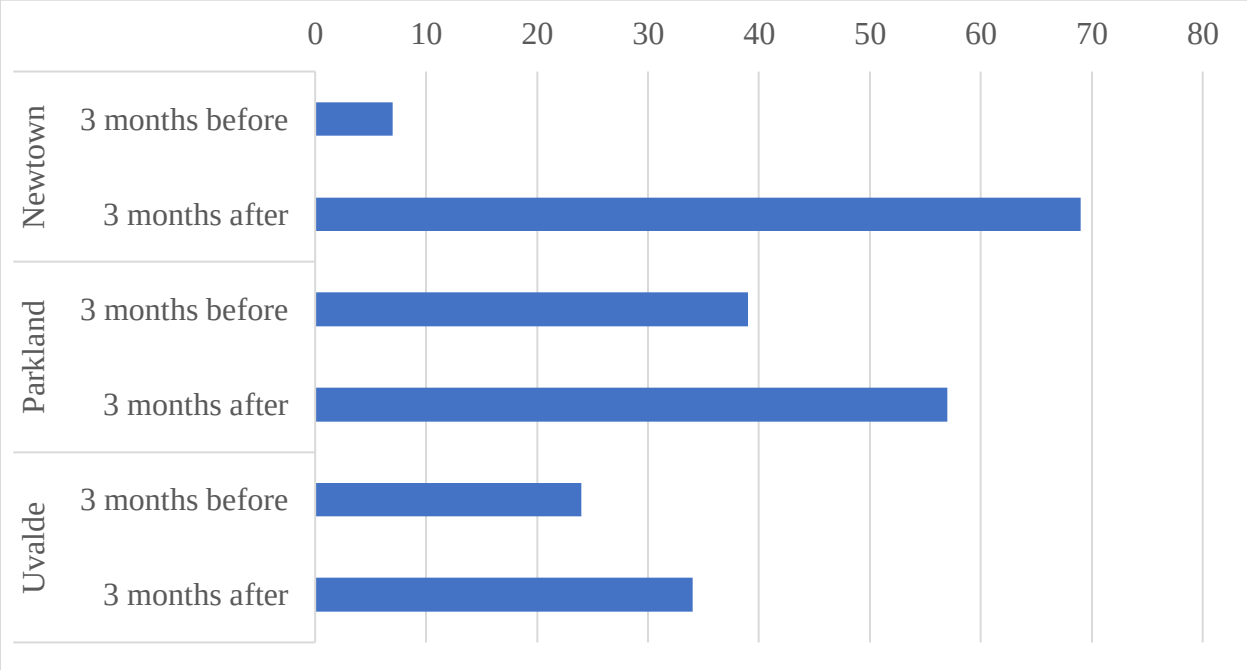
alternative mental health policy or another community mental health policy to couple with the problem of mental illness allegedly causing violence. I find no support for this hypothesis. Lawmakers did not reference the Parkland school shooting in discussions of any significant mental health policies adopted or community mental health policies introduced in the four years after the Parkland shooting. Further, policy entrepreneurs did not modify any community mental health policy proposals on the legislative docket in the year after Parkland. Taken together, I find no evidence that Parkland motivated political actors to couple an alternative policy with the problem garnering attention after the focusing event.

Third, maybe a bipartisan coalition of lawmakers supported the community mental health policy proposal after Newtown and Uvalde, but only one party supported the policy after Parkland. Again, I find no support that partisan policy support from sponsors explains the difference in coupling outcome. Before or immediately after each school shooting, the same bipartisan champions, Senators Blunt (R-MO) and Stabenow (D-MI) and Representatives Matsui (D-CA) and Lance (R-NJ), led a bipartisan coalition of lawmakers sponsoring the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act. This finding implies that partisanship in sponsorship also does not explain why political actors adapt community mental health policy proposals after a school mass shooting.

Fourth, possibly legislative attention toward gun control differed after Parkland compared to Newtown and Uvalde. Perhaps Congress pursued gun reforms in the wake of Parkland that monopolized legislative attention and distracted political actors from coupling community mental health proposals with the problem of mental illness allegedly causing violence, but after Newtown and Uvalde, there was no such legislative push for gun control, leaving legislative capacity available to pursue community mental health bills. Once again, I find no support for this

potential explanation. Figure 1.2 portrays the number of firearms-related bills acted upon in the three months before and after each shooting. Acted upon includes changes in the status of a bill in the legislative process, including introduction, referral to committee, and movement to the floor. The figure demonstrates that lawmakers acted on far more gun legislation in the three months after each mass shooting than in the months before. For instance, seven bills were introduced, assigned to a committee, or considered on the floor three months before Newtown compared to 69 in the three months after. More bills were also acted upon after Parkland and Uvalde than before (Parkland: before – 39, after - 57; Uvalde: before – 24, after - 34).[6] The figure illustrates that gun policy was a more prominent issue on the legislative agenda in the months after each shooting than the months before.

Figure 1.2: Legislative Actions Related to Gun Policy



Note: The graph depicts the date of the last action on legislation related to firearms in the three months before and after each shooting. Possible actions include introduction, referral to committee, and movement to the vote for a

[6] One might be surprised that the increase in legislative actions related to gun policy is smaller after Uvalde than after Newtown and Parkland. This is because the main bill related to gun policy introduced after Uvalde was an 80-page bill containing many different provisions. In contrast, gun control legislation after Newtown and Parkland is characterized by several smaller bills. Consequently, there were more bills introduced following Newtown and Parkland, but they were of smaller scope.

vote. I identified the date of last action by searching the text string "gun*" OR "firearm*" in the Legislation search of congress.gov.

For instance, after Newtown, President Obama formed an interagency gun violence task force headed by then Vice President Joe Biden. In addition to 23 executive actions, the resulting task force plan included 12 proposals for Congress, including bills banning assault weapons and requiring background checks on all commercial gun sales – both of which failed when brought to a vote on the Senate floor (Feinstein 2013; Manchin 2013; The White House 2013). After Parkland, Congressional leaders introduced bills that banned bump stocks (Giffords: Courage to Fight Gun Violence 2018c), raised the age of purchasing a semi-automatic weapon (Giffords: Courage to Fight Gun Violence 2018a), enhanced background checks, required law enforcement to be notified when a prohibited person tries to buy a firearm and is denied by the National Instant Criminal Background Checks System (NICS) (Giffords: Courage to Fight Gun Violence 2018d), and expanded the use of extreme risk protection orders (Giffords: Courage to Fight Gun Violence 2018b; Newell 2018). And after the shooting in Uvalde on May 24th, 2022, a bipartisan coalition of senators developed a framework outlining the provisions of a gun violence prevention bill within three weeks of the shooting. The 80-page bill was introduced in the Senate on June 21st, passed days later, affirmed in the House on June 24th, and signed by the president on June 25th (S.2938 2022). It included provisions related to extreme risk protection orders, extending prohibitions on firearm purchases to dating partners convicted of domestic abuse, providing NICS an additional seven days to conduct some background checks, and harsher penalties for gun trafficking (Horwitz and Cantrell 2022). In summary, gun control reached the top of the legislative agenda following each mass shooting, suggesting that the legislative attention afforded to gun policy does not explain the decision to pursue coupling following each mass shooting.

Finally, it is also possible that the party possessing the majority of seats explains why political actors coupled community mental health policy proposals after Newtown and Uvalde but not Parkland. Indeed, perhaps the public policy preferences of the majority party influence the decision to pursue coupling after a mass shooting. When Democrats are in the majority, political actors may be more likely to engage in coupling. Generally, Democrats are more likely to support reforms that expand public health access than Republicans (Adolph et al. 2021; Conlan 1998; Grogan et al. 2020; Grogan and Rigby 2009; Jacobs and Callaghan 2013; D. K. Jones 2017; D. K. Jones, Bradley, and Oberlander 2014; D. K. Jones, Singer, and Ayanian 2014), [7] implying that Democrats have a greater interest in adopting a coupled community mental health policy. At the same time, political actors may also be incentivized to couple when Republicans have the majority of seats. Republicans may pass mental health policies after mass shootings to distract from reforms related to gun control. Thus, Democrats or Republicans possessing the majority may predict when political actors couple community mental health policy reforms with the problem of mental illness allegedly causing violence.

I find no support for the explanation that possessing the majority of seats predicts coupling. Beginning with the House, the Republican party controlled the chamber at the time of Newtown (234 seats to 201 Democratic seats) and Parkland (241 seats to 194 Democratic seats),

[7] For example, partisanship is an important component of why so many states rejected to create their own health insurance exchanges and expand Medicaid under the Patient Protection and Affordable Care Act (Grogan et al. 2020; Jacobs and Callaghan 2013; D. K. Jones 2017; D. K. Jones, Bradley, and Oberlander 2014; D. K. Jones, Singer, and Ayanian 2014). Republicans are more likely than Democrats to propose block grants, which limit federal expenditure by providing state and local governments a set amount for public health programs over matching structures, where the federal financial contribution is a percentage of state expenditures (Conlan 1998; Grogan and Rigby 2009). Republican governors were slower to adopt social distancing policies than Democrats in response to the COVID-19 pandemic (Adolph et al. 2021). It is important to note that research also demonstrates that partisanship is an incomplete explanation of many public health policy outcomes. For instance, D. K. Jones (2017) shows that Republican lawmakers were hardly unanimous in their decision to reject legislation that established a state exchange. Grogan and Rigby (2009) show that partisanship does not predict political support for block grants after implementation. While I do not investigate intraparty differences here, I acknowledge the likely within party variation that exists despite these interparty generalizations.

so House control cannot explain the difference in coupling outcome. But what about the Senate? Notably, while Republicans controlled the Senate at the time of Parkland, the Democratic party controlled the Senate when Newtown and Uvalde occurred, suggesting that something related to Senate party control may explain the decision to engage in coupling after Newtown and Uvalde but not Parkland. However, simply possessing the majority of seats cannot explain the decision to pursue coupling after each mass shooting because no party ever had a filibuster-proof voting base at the time of the shooting. Put another way, a common feature of the three mass shootings examined here is that the party in control of the Senate had a slim majority. Indeed, the partisan difference when each shooting occurred were marginal: Newtown - 53 Democratic, 45 Republican; Parkland - 51 Republican, 47 Democratic; Uvalde - 48 Democratic, 50 Republican.[8] These small majorities imply that the majority party did not have enough seats to guarantee the votes needed to pass the community mental health policy, as these policies were likely not exempt from the filibuster and required a minimum of 60 votes to adopt.

Moreover, the adoption of the coupled community mental health bills passed after Newtown and Uvalde provide further support that votes from both parties were needed to pass the reform. Following Newtown, 46 Democrats (87.0% of all Senate Democrats), 16 Republicans (36.0%), and 2 Independents (100.0%) voted in favor of the law that contained the Excellence in Mental Health Act. After Uvalde, 48 Democrats (100.0%), 15 Republicans (30.0%), and 2 Independents (100.0%) voted in factor of the bill containing the Excellence in Mental Health and Addiction Treatment Expansion Act. Thus, I find no support that simply possessing the more seats explains why political actors engaged in coupling after a mass shooting.

[8] Two independents voted with the Democratic party and Democrats controlled the presidency at the time of Uvalde, leading to a Democratic majority in May 2022.

But perhaps something else related to majority control explains the difference in coupling outcome. The majority party not only benefits from more seats than the minority but also possesses unique agenda setting powers that provide them immense control over which bills progress through or stagnate in the legislative process. In the following section, I outline my argument for why agenda support from majority leaders, not simply possessing majority control, was crucial to the decision to engage in coupling community mental health policy proposals with the problem of mental illness allegedly causing violence.

1.5 Agenda Setters

If shooting profile, community mental health policy, bipartisan support, gun agenda, and possessing the majority of seats do not impact the decision to engage in coupling after a school mass shooting, what then explains why political actors adapted community mental health policy proposals after Newtown and Uvalde to align with the problem of mental illness allegedly causing violence, but not Parkland? I find that judgments about how *agenda setters* will use their influence over a bill's advancement explains why political actors engaged or did not engage in coupling community mental health policy proposals after these school mass shootings.[9] Agenda setters are members of the majority party, like the chairs of committees and subcommittees, who possess immense control over which bills climb the legislative agenda and which stagnate in committee. Following Newtown and Uvalde, agenda setters influencing the legislative process of mental health bills in the Senate and House – some Democrats and some Republicans – supported the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act. The agenda setters at the time of Parkland did not

[9] Again, I provide a brief explanation of this concept here and describe it in more detail in Chapter 2.

support the equivalent community mental health policy proposal. I argue that this difference in policy support from these individuals explains the decision to engage in coupling after Newtown and Uvalde, ultimately contributing to the significant expansions of community mental health policy after these two shootings, and the decision not to pursue coupling after Parkland.

Agenda setters impact coupling because of their disproportionate influence over the legislative agenda. Agenda setters possess powers, such as determining which bills are considered on the floor and under what procedures, that allow them to collectively determine which legislation arrives on the legislative agenda: the list of items actively being decided upon by Congress (Campbell, Cox, and McCubbins 2002; Cox and McCubbins 2005; Jenkins and Monroe 2016). Since the objective of coupling after a focusing event is to move the proposal to the top of the legislative agenda, the political actors responsible for coupling judge whether agenda setters will use their controls over the agenda to block or expedite a bill in the legislative process. Put another way, political actors will only engage in coupling if they receive a signal from agenda setters, such as bill sponsorship or displays of support through rhetoric, that they are unlikely to use their agenda powers to block the coupled policy from reaching the floor. Otherwise, the public policy benefits of coupling do not outweigh the costs of the coupling process, and political actors do not pursue proposal adaptation.

Lawmakers occupying these agenda setting positions provided this display of support for the Excellence in Mental Health Act or Excellence in Mental Health and Addiction Treatment Expansion Act before or at the onset of the coupling process after the Newtown and Uvalde shootings. The chair of the Senate and House committees and subcommittees where community mental health policy reforms were referred publicly supported the legislation through sponsorship. Further, statements from other lawmakers explicitly thanked the committee chairs

for progressing the bills through the legislative process. In contrast, the lawmakers in relevant agenda setting positions at the time of Parkland never displayed support for the Excellence in Mental Health and Addiction Treatment Expansion Act. Indeed, no lawmaker in the positions of party leader, whip, committee chair, or subcommittee chair at the time of Parkland sponsored any version of the legislation or released a statement about community mental health. This finding suggests that not a single agenda setter with influence over the advancement of these community mental health bills possessed an interest in using their agenda controls to progress the legislation. Further, the lack of support may imply that leadership would block the bill from reaching the floor.

I examine this argument – agenda setters because of their control over a bill's legislative fate – explain why political actors coupled community mental health policy with the problem of mental illness allegedly causing violence after Newtown and Uvalde but not Parkland – in detail throughout the rest of this dissertation. [10]

[10] In a nutshell, my argument is that support from agenda setters was crucial for political actors to pursue coupling of community mental health policy proposal with the problem of mental illness allegedly causing violence after the three mass shootings examined in this dissertation. I will show that this support existed in the cases of Newtown and Uvalde, where proposal adaptation ensued after the mass shooting, but not Parkland, where coupling remained elusive. However, I do not answer why agenda setters sometimes provided this support but other times did not. This may bias my results since agenda setters who supported and did not support community mental health policy may differ in ways that matter to the decision to pursue coupling. Put another way, the decision to support a community mental health policy proposal may impact whether political actors engaged in coupling following Newtown and Uvalde but did not pursue coupling after Parkland. This potential bias is not a concern for Democratic agenda setters. Since at least one member of Democratic leadership always supported the community mental health policy when they were in control of a chamber, I am not concerned that the decision to support the policy biases my finding that agenda setters are critical to the decision to engage in coupling. However, the Republican agenda setters who supported the policy may differ in important ways from those who did not. I examine the prediction that the decision by the lawmakers occupying these positions to support the community mental health policy will only bias my results if the Republican agenda setters who supported the policy differ from the Republican legislators in the same position who did not support the policy. I test this hypothesis using DW-Nominate scores, comparing the score of Representative Joseph Pitts (R-PA) – the Republican lawmaker occupying the agenda setting position who supported the bill at the time of Newtown – to the score of Michael Burgess (R-TX) – the representative in the same position as Pitts who did not support the bill at the time of Parkland. Their DW-NOMINATE scores are not significantly different at 0.54 for Representative Pitts and 0.57 for Representative Burgess (χ^2: 0.42, p=0.51). This analysis demonstrates that the decision to support a policy by agenda setters likely does not bias my results.

1.6 A Quick Note on Methods

I use a most similar systems design (MSSD) to examine the mechanisms of community mental health policy proposal coupling, and why it occurred after some school mass shootings but not others. An MSSD attempts to select and compare cases that are as similar as possible except with regard to the studied phenomenon. This approach aims to choose cases that allow the researcher to keep constant as many variables as possible (Anckar 2008). Put another way, MSSD studies include cases that "are similar on specified variables other than X_1 and Y" (Seawright and Gerring 2008, 298). This approach allows the researchers to, ideally, isolate the effect of their primary independent variable on the outcome of interest.

Examining the cases of the Newtown, Parkland, and Uvalde mass shootings facilitates an MSSD. As discussed earlier, the Newtown, Parkland, and Uvalde tragedies share many features but differ in my main independent and outcome variables. Regarding my independent variable, agenda setters relevant to the Excellence in Mental Health Act or Excellence in Mental Health and Addiction Treatment Expansion Act supported these bills before or immediately after the mass shootings in Newtown and Uvalde, but not Parkland. Newtown and Uvalde also resulted in coupling the community mental health policy proposals with the problem prioritized by the focusing effect. On the other hand, political actors made no such policy adaptations after Parkland. Taken together, the variability in my independent variable (i.e., support from agenda setters) and outcome of interest (i.e., coupling) paired with consistency in the other specified variables (i.e., shooting setting, policy, and bipartisan support) facilitate the MSSD framework.

Within the MSSD, I combine qualitative and quantitative methods to examine the mechanisms of coupling and why it occurs. To assess whether politicians coupled proposal rhetoric with the problem prioritized after each mass shooting, I rely on a content analysis of 555

floor remarks and press releases made between 2009 and 2022: years when lawmakers introduced a version of the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act. This analysis allows me to capture aggregate trends in rhetoric related to community mental health policy and whether focusing events explain the evolution of these trends. In examining whether policy entrepreneurs coupled proposal design with the problem capturing attention after each mass shooting, I rely on a variety of primary sources, specifically formal policy documents, including laws and bills, and other government records to trace whether and how policy entrepreneurs adapted the design of community mental health policy after each mass shooting. Finally, in answering why coupling occurs after some school mass shootings but not others, I combine evidence from various primary and secondary sources. These documents include sponsorship records, legislative testimonies, press releases, advocacy documents, and media articles.

1.7 Contributions

My dissertation promises significant contributions for public health and political science. The public health value stems from my demonstration that harmful misconceptions about mental health and public safety have important implications for mental health policy reforms. As noted earlier, people with a mental illness, including those with a severe mental illness, are no more likely to commit acts of violence than their peers without a mental illness, and the majority of gun violence perpetrators do not have a mental illness or serious mental illness (Burris et al. 2010; Elbogen and Johnson 2009; Fazel et al. 2009; McGinty et al. 2014; Metzl and MacLeish 2015; Metzl, Piemonte, and McKay 2021). Consequently, it is far from likely that expansions of

the mental health treatment system will prevent another Newtown, Parkland, Uvalde, or one of the thousands of other mass shootings that occurred in the United States over the past 15 years.[11]

This perceived yet inaccurate relationship is not harmless. A robust collection of research demonstrates that depictions of persons with a mental illness as violent increase stigma (McGinty et al. 2015; McGinty, Pescosolido, et al. 2018; Pescosolido, Manago, and Monahan 2019). For instance, a randomized survey experiment examined the effect of characterizations of persons with serious mental illness on investment in the mental health system. The study revealed that frames that link serious mental illness with violence significantly heightened stigma toward people with mental illness and were no more effective at improving willingness to invest in treatment in comparison to non-stigmatizing messaging (McGinty, Goldman, et al. 2018). Another survey-embedded randomized experiment examined the impact of news stories about mass shootings on public attitudes towards persons with serious mental illness, finding that stories about a mass shooting increased desired social distance from persons with serious mental illness and perceptions that these individuals are dangerous (McGinty, Webster, and Barry 2013).

However, this false and stigmatizing association between mental illness and violence has important implications for mental health policy. The mass shootings examined in this dissertation heightened attention to the preexisting conception that mental illness allegedly causes violence. In the cases of Newtown and Uvalde, the prioritization of this perceived relationship awakened the paralyzed policy space of community mental health and catalyzed a policymaking process that produced important expansions of the community mental health treatment system. Put another way, my dissertation demonstrates that the adoption of policies

[11] See Appendix A for a list of several of these other mass shootings.

that benefit community mental health – a crucial safety net provider within the mental health treatment system – has become a dependent variable of some mass shootings. I am the first to attempt to examine and explain how and why some mass shootings, through increasing attention to the mistaken, pernicious association between mental illness and violence, have this effect on mental health policymaking.

This dissertation also offers several insights for political science scholars. First, I expand upon the coupling process described in Kingdon's *Agendas, Alternatives, and Public Policy* (1984). While Kingdon contributes an immense array of concepts and ideas in his seminal work, he describes his coupling process generally, failing to consider the granular activities involved in coupling and answering why coupling ensues following some focusing events and not others. I address these limitations in several ways. I define the nuanced activities embedded within coupling processes triggered by focusing events. Specifically, I demonstrate that political actors engage in both rhetorical and design adaptations to align a policy proposal with the problem and political environment. In addition, I provide an answer to why some focusing events initiate coupling while others do not. All focusing events create incentives to engage in coupling by providing a problem political actors can attach to their policy proposals, but individuals only act on these incentives after some focusing events. I find that the decision to initiate coupling after a focusing event depends on judgments about how agenda setters may use their agenda controls to prevent the coupled policy from advancing through the legislative process. These two expansions – the addition of granularity into coupling and the exploration into why coupling follows some focusing events but not all – offer important extensions of Kingdon's influential book.

Second, I shed light on bipartisanship in today's polarized age. Since the mid-1970s, partisan polarization has grown steadily, making it increasingly challenging to adopt legislation

with bipartisan support (Bateman, Clinton, and Lapinski 2017; D. R. Jones 2010; McCarty, Poole, and Rosenthal 2006; Rohde 1991). I find that focusing events create rare opportunities for bipartisan policymaking in this polarized environment. My definition of a focusing event requires that the event increase attention to a problem among Democratic and Republican politicians and voters, as well as among individuals representing a range of ideological orientations within parties. In order to act on these incentives and pass a bill, the majority party in the Senate often requires support from the other party. This situation, where each party is motivated to identify the solution to the problem spotlighted by the focusing event, and the majority party needing minority members to adopt this solution, uniquely incentivizes lawmakers to work together. Indeed, they may search for a common ground proposal that would have been inconceivable in times when Democratic and Republican voters and lawmakers were not tuned into the same problem.

In addition to the contributions specified above, this dissertation adds to political science scholarship in a few other ways. I offer an operationalization for focusing events that other researchers can replicate. I expand upon Kingdon (1984)'s concept of *alternative specification* by considering it at both granular and general levels.[12] Specifically, I examine how policy entrepreneurs choose between various options for policy specifics during coupling to accommodate new political interests in a problem following a focusing event. I also assess whether general alternative specification, meaning the selection of a policy approach as opposed to policy details, is a possible alternative hypothesis for why political actors did not engage in coupling after the shooting in Parkland, Florida. Taken together, these contributions demonstrate that this dissertation furthers both political science and public health scholarship.

[12] I describe this concept in more detail in Chapter 6.

1.8 Dissertation Plan

The following five chapters offer an in-depth analysis of why the Newtown and Uvalde mass shootings led political actors to engage in the coupling of significant community mental health policy proposals, contributing to the passage of these policies, while a similar shooting in Parkland did not affect the adaptation of the same proposals. Chapter 2 provides a detailed theoretical overview of my argument, taking a step back from my cases of interest and thinking about the role of focusing events in coupling generally. I begin by defining a focusing event. I then describe how focusing events incentivize the two mechanisms by which coupling occurs: rhetoric and design adaptations to align the proposal with the problem prioritized by the focusing event. Next, I provide a detailed description of why agenda setters impact the decision to engage in coupling because of their agenda setting powers. Finally, I apply these general variables and argument to the focus of this dissertation: school mass shootings and community mental health policy.

Chapter 3 begins the presentation of my empirical analysis. The chapter examines one of the two mechanisms by which coupling occurs – proposal rhetoric – answering which mass shootings led politicians to modify how they describe community mental health policy proposals. I capture the evolution of violence rhetoric in 555 floor remarks and press releases related to community mental health policy released from 2009 to 2022. Violence rhetoric refers to statements suggesting that an individual or group harmed or may harm another individual or group. For instance, descriptions implying that community mental health policy proposals were necessary to improve the mental health treatment system so that it intervenes before "someone does something that tragically impacts their lives and the lives of others" (Blunt 2013a). I present the data using aggregate trends to illustrate systematic shifts in how politicians describe

community mental health policy proposals. I find that the Newtown shooting in December 2012 and Uvalde shooting in May 2022 explain rapid increases in violence rhetoric in 2013 and 2022. However, the mass shooting in Parkland did not impact the prevalence of violence descriptions in the rhetoric used by politicians to describe community mental health proposals. Taken together, this chapter establishes that the Newtown and Uvalde mass shootings, but not Parkland, led politicians to engage in the rhetorical component of coupling, while Parkland had no impact on community mental health proposal descriptions.

In Chapter 4, I expand upon the findings in Chapter 3 by examining how increasing the use of violence rhetoric after a mass shooting couples a community mental health policy proposal with the problem prioritized by these events. I use the focusing event of the Newtown shooting. My analysis demonstrates that Newtown transformed how politicians discussed the Excellence in Mental Health Act. Before Newtown, lawmakers described the bill using various specific populations and disorders within the general category of mental illness. After Newtown, lawmakers newly described the Excellence in Mental Health Act as the solution to the problem of mental illness allegedly causing violence. Indeed, politicians used rhetoric to explicitly attach their policy proposal – the Excellence in Mental Health Act – with the problem capturing public attention after Newtown.

Chapter 5 departs from the previous two chapters by examining the other mechanism by which coupling occurs: adaptation of proposal design. I demonstrate that policy entrepreneurs adapted the design of the Excellence in Mental Health Act after Newtown and the Excellence in Mental Health and Addiction Treatment Expansion Act after Uvalde to accommodate new political interest in the problem prioritized by the focusing events. Both mass shootings increased Republican political attention to the problem of mental illness allegedly causing violence. Policy

entrepreneurs responded to this increase in political attention by adapting the design of each bill to reflect the public policy preferences of Republicans. Indeed, policy entrepreneurs reduced the scope of the bills to accommodate Republican preferences for small government programs and devolved regulatory responsibilities.

This chapter also begins to answer why Newtown and Uvalde led to the coupling of community mental health policy proposals with the problem prioritized by each shooting: mental illness allegedly causing violence. I identify support for my argument that agenda setters who have control over the advancement of community mental health bills likely influenced the decision to couple community mental health policy with the problem garnering attention after each focusing event. Lawmakers occupying agenda setting positions, specifically the chairs of the Senate committee and House subcommittee where the Excellence in Mental Health Act (after Newtown) and Excellence in Mental Health and Addiction Treatment Expansion Act (after Uvalde) were referred, sponsored the iterations of the bill before or immediately after each shooting. This support from these agenda setters signaled that they would not use their agenda control to block the bill from reaching the floor vote. In fact, statements from other lawmakers thanking these individuals for their support suggest that these leaders may have deployed positive agenda controls to expedite the bills through the legislative process. The chapter reveals that judgments about how these agenda setters would use their controls over bill progression likely influenced the decision of political actors to engage in the coupling of community mental health policy proposals with the problem capturing attention after the Newtown and Uvalde focusing events, ultimately contributing to the adoption of these significant community mental health policy reforms.

In Chapter 6, I turn to Parkland: a mass shooting that did not lead political actors to adapt a similar community mental health policy proposal to that pursued after Newtown and Uvalde. This chapter first establishes that political actors did not engage in coupling after Parkland. Politicians and policy entrepreneurs did not change community mental health proposal rhetoric or design to reflect heightened attention to the problem of mental illness allegedly causing violence. I then turn to the role of agenda setters in the decision not to engage in coupling. I demonstrate that, unlike in Newtown and Uvalde, the persons occupying the positions with extensive agenda control over community mental health bills at the time of Parkland never expressed support for the bills related to the Excellence in Mental Health Act or its expansion. Without this display of support, the political actors responsible for coupling chose not to engage in the adaptation process, as there was uncertainty about leadership using their agenda controls to block the coupled bill from reaching the floor.

Finally, in Chapter 7, I discuss the lessons learned about how mass shootings impact mental health policymaking. I highlight how two of these horrific events have led to the most substantial community mental health care reforms in over thirty years. Indeed, the Excellence in Mental Health Act passed after Newtown and the Excellence in Mental Health and Addiction Treatment Expansion Act enacted after Uvalde represent transformational community mental health care policies. However, the evidence from Parkland, and the hundreds of other mass shootings, demonstrate that these events rarely lead to the expansion of community mental health policy. Indeed, this dissertation reveals that without a supportive political infrastructure, specifically investment from lawmakers occupying relevant agenda setting positions, these tragedies more often than not go to waste (Emanuel 2020).

Chapter 2 Focusing Events, Coupling, and Agenda Setters

My goal in this dissertation is to explain why the Newtown and Uvalde mass shootings led political actors to adapt community mental health policy proposals to align with the problem of mental illness allegedly causing violence, leading to the most substantial reforms in community mental health policy in thirty years, but Parkland did not affect the adaptation of the same proposals. This question has several theoretical concepts described in detail in this chapter (see Table 2.1). While the rest of the dissertation focuses narrowly on the Newtown, Parkland, and Uvalde mass shootings and community mental health policy, this chapter takes a step back. Put another way, I describe concepts generally to be then applied to the mass shootings and community mental health policies examined in the rest of this thesis.

Table 2.1: Variable Definitions

Focusing event	A rare and sudden event that rapidly increases public and political attention to a problem, so much so that the problem becomes a priority issue
Public attention	The amount of public interest in a problem from non-political actors (e.g., mentions of a problem in the media, social media)
Political attention	The amount of interest in a problem from political actors (e.g., mentions of a problem in floor remarks, press releases, votes on or sponsorship of policies addressing problem)
Coupling	The process by which political actors adapt a policy proposal so that it becomes the perceived solution to a problem in a way that is amenable to the political environment
Policy proposal	Formal, written policy proposals (e.g., bills)
Policy proposal rhetoric	The rhetoric used to describe a policy proposal
Policy proposal design	The content of a policy proposal
Agenda setting power	The ability of the majority party to affect which bills are voted on by a legislature
Agenda setter	Members of the majority party who have substantial influence over the legislative agenda (e.g., committee and subcommittee chairs)

The chapter proceeds as follows: first, I define a focusing event, such as the Newtown, Uvalde, and Parkland mass shootings, as events that rapidly increase attention to a problem. Second, I describe how focusing events incentivize coupling: the process by which political actors adapt a policy proposal so that it becomes the perceived solution to a problem in a way that is amenable to the political environment. I provide a nuanced understanding of the specific mechanisms by which coupling takes place, identifying that focusing events motivate two adaptations related to proposal rhetoric and proposal design. Third, I argue that judgments about how agenda setters may use their controls over a coupled bill's progression explain why political actors engage in coupling after some focusing events but not all. Finally, I apply these concepts to the Newtown, Parkland, and Uvalde mass shootings and community mental health policy.

2.1 Focusing Events

Sometimes events occur that demand universal attention. Take, for example, the January 6th, 2021 insurrection at the U.S. Capitol. Following the reelection defeat of President Donald Trump, a mob of over 2,000 of his supporters entered the U.S. Capitol in an attempt to prevent a joint session of Congress from certifying the electoral college votes that would formalize President Joe Biden's electoral win. The attack led to the deaths of seven persons, including three police officers (Cameron 2022). On January 7th, the front pages of the top five US newspapers by circulation contained headlines related to the January 6th Capitol attack: "After Pro-Trump mob storms Capitol, Congress confirms Biden's win," *The New York Times*; "Congress certifies Biden win after mob storms Capitol," *The Wall Street Journal*; "4 dead after mob stormed Capitol," *USA Today*; "Congress affirms Biden win hours after pro-Trump mob storms U.S. Capital," *The Washington Post*; and "Pro-Trump mob storms the U.S. Capitol,

forces lawmakers to flee," *The LA Times*. The January 6th, 2021 attack is an unequivocal example of an event that absorbed attention.

These occurrences are called *focusing events*: rare and sudden events that rapidly increase public and political attention to a problem, so much so that the problem becomes a priority issue. I break this definition into three parts. First, I adopt the rare and sudden components of my definition directly from Birkland (1997, 22).[13] Focusing events must be rare because events that occur frequently are more likely to be classified as trends. They are sudden because if they were incremental, they would not be tied to a particular event. Second, focusing events must increase public and political attention to a problem. This component also comes from Birkland (1997). Without the public and politicians caring about the problem spotlighted by the event, the event will not become a priority issue. Public attention is the amount of public interest in a problem, for instance, the amount of media coverage or social media posts. Political attention, on the other hand, is the amount of interest in a problem from political actors. Political actors display problem interest in a variety of ways, including calling hearings, releasing public statements, sponsoring legislation, and placing votes.[14]

Finally, the event must increase problem attention, so much so that the problem becomes a priority issue for a substantial majority of the public and politicians. This element stems from Kingdon's (1984) conception of focusing events as events that "simply bowl over everything standing in the way of prominence on the agenda" (96). I ensure that I meet this criterion in two ways. First, the event must heighten attention to the point where the problem becomes a top

[13] Birkland (1997) defines a potential focusing event as an event that is "sudden, relatively rare, can be reasonably defined as harmful or revealing the possibility of potentially greater future harms, inflicts harms or suggests potential harms that are or could be concentrated on a definable geographical area or community of interest, and that is known to policymakers and the public virtually simultaneously" (22).

[14] Public attention and political attention to a problem are related. Indeed, behaving in ways that align with voter preferences, including by giving attention to the issues of concern to voters, portends political benefits for electorally minded politicians.

priority. This is the blurriest element. As Birkland (1998) writes, "some events are more intensely 'focal' than others" (54). Sometimes events focus next to all public and political attention on a problem, for instance, the terrorist attacks on September 11, 2001. In contrast, other events increase problem attention but do not surge it to the top of public and political interest.

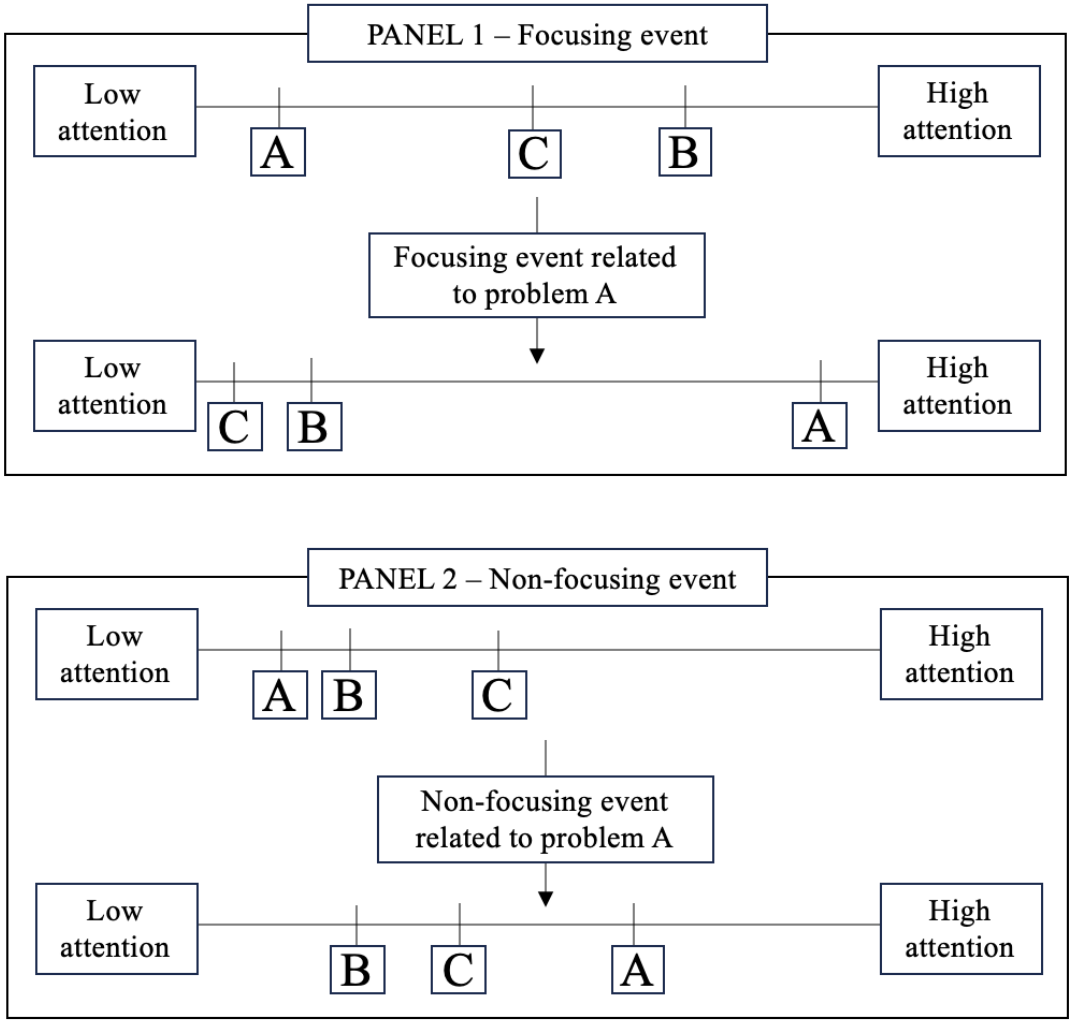
I illustrate this fuzziness in Figure 2.1. The boxes, A, B, and C depict different problems, for instance, inflation, immigration, and climate change, capturing some degree of public and political attention.[15] Sometimes the amount of interest in a problem is low, and other times it is high. I place the amount of attention afforded to each of these problems on a single dimension, ranging from low attention to high attention. An event – whether it is focusing or not – may disrupt the distribution of these problems along this attention dimension, as depicted in Panels 1 and 2. Panel 1 contains a focusing event related to problem A, and Panel 2 includes an event that is not focusing but is also related to problem A. Both incidents change the amount of attention afforded to problems A, B, and C, so the distribution of the problems on the attention dimension differs before and after the focusing event or non-focusing event.

Focusing events differ from non-focusing events in that they knock all attention away from problems B and C and substantially heighten attention toward problem A. I depict this bowling over phenomenon in Panel 1. A focusing event related to problem A substantially increases attention to the problem, moving it along the attention dimension from low to high and nearly eliminating attention to problems B and C. Put another way, problem A newly monopolizes attention after the focusing events. On the other hand, events that are not focusing

[15] For the sake of simplicity, I combine public and political attention into a single dimension, but the degree of public attention afforded to a problem may differ from the degree of political attention afforded to that same problem. However, for an event to be focusing, it must raise public and political attention, so much so that the problem becomes a priority to both the public and political actors.

may increase attention to the problem spotlighted by the incident but do not increase attention so much so that it is the only problem of interest. Panel 2 provides an example of one of these non-focusing events. The event raises attention to problem A, but attention remains divided between the three problems. Indeed, problems B and C still capture a non-marginal amount of attention. In this dissertation, I am interested in the focusing event of Panel 1: events that displace interest in other problems and concentrate that attention on the problem involved in the focusing event.

Figure 2.1: Focusing Event vs. Event



Note: A, B, and C are different problems.

The second way I meet the criterion that a focusing event must bowl over all other issues is by exclusively examining focusing events that raise public and political attention among members of both parties. An event may substantially increase public and political attention to a problem among a small group or the entire country. I am exclusively interested in focusing events that heighten (1) public attention among a majority of voters from both parties and (2) political attention among politicians representing both parties and ideological diversity within parties. By examining these types of events, I ensure that the event is undoubtedly focusing.

Taken together, a focusing event rapidly heightens public and political attention to a problem so that it becomes a top priority. This rise in attention occurs among a substantial majority of the public, including voters from both parties. The increase in political attention involves Democratic and Republican representatives and politicians with diverse ideological orientations within parties. Now that I have defined a focusing event, I turn to how focusing events incentivize politicians to adapt policy proposals to align with the problem prioritized by the event through a process called coupling.

2.2 Focusing Events and Coupling

Focusing events create opportunities by which political actors can hook their policy proposal to the problem garnering attention after the event. Focusing events, like a disaster or a crisis, convert problems from insignificant to pressing: an airline crash focuses attention on airline safety, or a tsunami highlights attention to the growing risk of climate change. Political actors can seize upon these opportunities where a problem becomes a priority and attach their proposal as the solution to the problem. For instance, the 2008 stock market crash spotlighted significant deficits in the federal financial regulatory system. Political actors seized upon this focusing event and the Democratically controlled Congress and presidency to place sweeping

reforms that reorganized the financial regulatory system at the top of the legislative agenda, ultimately leading to their enactment (Greene 2011).

This process, by which political actors adapt existing policy ideas to match the problem garnering attention after a focusing event, is known as *coupling*. As described in John Kingdon's *Agendas, Alternatives, and Public Policy* (1984), coupling involves the joining of Kingdon's three independent streams: problem, politics, and policy. The problem stream contains the issues with the attention of people in and around government. Focusing events impact this stream. Specifically, these events place or prioritize problems within the list of items that people in government pay attention to or are deciding upon. The political stream is comprised of the people and features of political institutions and communities (e.g., partisan and ideological distribution in Congress, parliamentary rules, interest groups) that characterize the political context. The final policy stream includes the policy entrepreneurs and their many policy alternatives or proposals. Policy entrepreneurs are the individuals who design, write, and amend policy proposals, like academics, civil servants, staffers, and other experts (Greer 2016, 421). Coupling occurs when political actors seize an opportunity in the problem stream (e.g., focusing event) or politics stream (e.g., new administration) by adapting policy proposals to align with the problem and political environment. This adaptation process increases the likelihood that politicians prioritize the proposal on the legislative agenda – the list of items that politicians are actively deciding upon – enhancing the probability that the bill will become law.[16]

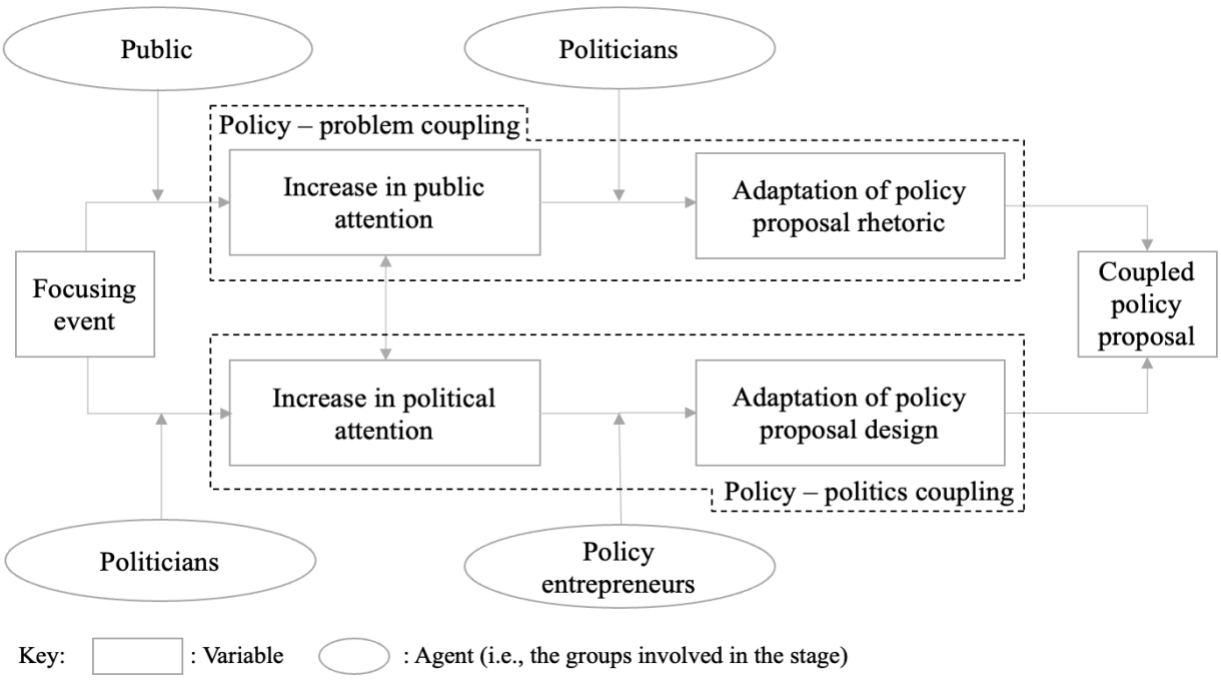
[16] Kingdon (1984) calls the legislative agenda the decision agenda. He contrasts the decision agenda with the government agenda. The governmental agenda "is the list of subjects people in and around government are paying serious attention," and the decision agenda is the subset of the government agenda that "is being decided upon," for instance, being moved in position for legislative enactment (166). Put another way, the distinction between the governmental agenda and decision agenda intends to separate issues that government cares about from those they are actively deciding about. Importantly, being on the decision agenda does not guarantee policy adoption; it just means it is an active policy area.

Thus far, I have explained that focusing events incentivize political actors to engage in coupling. In response to a focusing event prioritizing a problem, political actors are motivated to adapt existing policy proposals to become the solution to this problem in a politically feasible way. But how does coupling happen? What are the mechanisms involved in the coupling process after a focusing event? While the idea of coupling is powerful, it is also one of "…the most theoretically difficult parts of *Agendas*" (Greer 2016, 422). Part of this difficulty reflects the lack of guidance from Kingdon (1984) on the elements of the coupling process. Most accounts of coupling, including Kingdon's own, fail to provide a granular examination of the range of strategies involved in proposal adaptation. This is problematic because political actors can choose how they adapt a policy proposal to align with the problem capturing attention after a focusing event. They may change a proposal's design, the rhetoric used to describe the proposal, or some combination. I offer this nuanced investigation to identify what happens during the coupling process.

I argue that focusing events incentivize political actors to make two adaptations to policy proposals to achieve a coupled proposal: a politically feasible proposal perceived as the solution to the problem capturing attention after the focusing event. I illustrate these two mechanisms within the coupling process in Figure 2.2. Boxes depict the variables involved in the coupling process, and ovals contain the agent responsible for the movement in the variable. For instance, a focusing event triggers an increase in attention among two agents: the public and politicians. On the figure's left, I begin by depicting a focusing event. A focusing event triggers an increase in attention to a problem from the public and an increase in attention from politicians. The two stages of the coupling process involve (1) the relationship between public attention and proposal rhetoric and (2) the relationship between political attention and proposal design. Beginning with

the former, in response to heightened public attention to a problem following a focusing event, politicians are incentivized to adapt their rhetoric describing the policy proposal. This adaptation aligns the problem stream (public attention to a problem) with the policy stream (proposal rhetoric). Moving to the second mechanism, in response to increased political attention to a problem, policy entrepreneurs are motivated to adapt the proposal's design. This adaptation aligns the politics stream (political attention to a problem) with the policy stream (proposal design). These two adaptations, together, greatly enhance the likelihood of producing a coupled policy proposal.

Figure 2.2: The Coupling Process After a Focusing Event



Why are both mechanisms involved in the coupling process? Focusing events incentivize political actors to make both adaptations because they serve different purposes. The adaptation of proposal rhetoric by politicians in response to increased public attention following a focusing

event convinces constituents that the proposal will fix the issue capturing public interest. The adaptation of proposal design by policy entrepreneurs in response to increased political attention to the problem modifies the proposal to reflect the new politicians, and their ideological and partisan preferences, interested in the issue following the focusing event.

In the following sections, I provide a detailed description of these two processes. I start with the relationship between public attention and policy proposal rhetoric. I then turn to the influence of political attention on the adaptation of policy proposal design.

2.2.1 Public Attention and Proposal Rhetoric

I expect that focusing events incentivize politicians to adapt policy proposal rhetoric to align with the problem garnering public attention after the event. In a previous section, I defined public attention: the amount of public interest in a problem, for instance, the amount of media coverage or social media posts. But what is proposal rhetoric?

Proposal rhetoric is the way politicians frame a policy proposal. Framing is describing what something is and how to think about it (Kinder 1998).[17] Most, if not all, policy proposals are multi-dimensional, and politicians can use language to direct focus to the dimensions of a proposal that they believe will benefit them electorally (B. D. Jones and Baumgartner 2005). Indeed, an electorally minded politician believes that a constituent is more likely to support him if he behaves in ways that align with the voter's preferences. Thus, the goal of politicians is to estimate the preferences of their constituents, privileging certain sects over others (Fenno 1978), and use the frames that align with these calculations because they engender political capital

[17] There are different types of framing (Chong and Druckman 2007, 2010; Iyengar and Kinder 1987). For instance, equivalency faming effects use logically equivalent but different phrases to produce distinct preferences. Issue framing involves the selection of a subset of potentially relevant topics over others, leading the speaker to divert attention to these considerations (Chong and Druckman 2010; Druckman 2004). Despite these differences, all types of framing effects cause individuals to focus on certain characteristics of an issue over others.

(Arnold 1990; Mayhew 1974). This process is ongoing, meaning that politicians frame and re-frame proposals to reflect constituency preferences in the hopes of reducing their electoral liability and providing political benefits to them and their coalition partners.

An essential part of proposal rhetoric is problem definition. What problem does the proposal solve? Politicians have many choices in how they frame the problem solved by the policy proposal in rhetoric. Rochefort & Cobb (1994) outline several of these features. These include statements about the origins of a problem.[18] Other features of problem definition include severity (e.g., does the seriousness of a problem merit valuable time on a limited policy agenda), incidence (e.g., is a problem decreasing, stable, or growing), novelty (e.g., is a problem unprecedented), and proximity (e.g., does a problem hit "close to home" or directly impact a valuable constituency). Politicians also have choices in defining the target population of a policy proposal. Politicians have an interest in discussing policies that "do 'good' things for 'good' people" and are "'tough' on 'bad' people" (Schneider, Ingram, and Deleon 2014, 106).

Politicians have more choices when selecting the rhetoric used to describe a proposal when problems are imprecise. Policies addressing problems with unclear boundaries provide politicians frequent opportunities to frame and re-frame problems using the attributes perceived as engendering the greatest political benefit. Mental health offers one such case. Approximately one in five U.S. adults currently live with a mental illness (National Institute of Mental Health 2023), but what is mental illness? While there are extreme states of mental illness that all observers would identify as pathological, the line between mental illness and mental wellness is blurry (Rochefort 1994). For instance, the 1999 Surgeon General's report on mental illness produced the following definition: "mental illness is the term that refers collectively to all

[18] Stone (1989) provides a framework to classify causal statements, including the origins of a problem, in politics based on actions (unguided vs. purposeful) and consequences (intended versus unintended).

diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (U.S. Public Health Service 1999). According to the definition, all deviations from mental health are mental disorders, implying that mental illness constitutes a broad range of disorders of varying degrees of severity and intensity.

This vague understanding of what qualifies as mental illness provides politicians many rhetorical choices. In contrast to proposals addressing clearly defined problems, proposals addressing the problem of mental illness offer opportunities to describe the problem using the frame associated with the greatest electoral benefits and fewest political repercussions. For instance, they may use rhetoric that describes mental illness using encompassing language. Examples include terms like "emotional disturbances," "emotional stress," "emotional wellness," "psychological stress," disorders "requiring counseling or guidance or advice," or "mental health problems." Other times, rhetoric focuses on sub-populations within the category of mental illness, like serious mental illness,[19] or overlapping populations, such as substance use disorders.

In sum, proposal rhetoric is the way politicians describe a policy proposal. An essential part of this description is problem definition, or the problem the proposal addresses. Politicians have many choices when describing a problem, and these choices are amplified when the

[19] Federal regulation defines persons with serious mental illness as adults with (i.) mental disorders that (ii.) impose functional limitations in major life activities for (iii.) a substantial duration. Examples of these illnesses include "schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability," and functional impairments including those related to interpersonal activities, concentration, and adapting to change (42 CFR § 483.102 n.d.; Goldman and Grob 2006). The equivalent term for children is serious emotional disturbance, defined as a condition adversely impacting a child's educational performance over a long period that exhibits one or more of the following characteristics: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors; (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; (C) Inappropriate types of behavior or feelings under normal circumstances; (D) A general pervasive mood of unhappiness or depression; and(E) A tendency to develop physical symptoms or fears associated with personal or school problems (34 CFR § 300.8 n.d.).

problem does not have clear boundaries, like in the case of mental illness. Given this potential variation in proposal rhetoric, in what ways do focusing events affect how politicians describe a policy proposal?

I argue that one of the mechanisms by which focusing events lead to coupling is by incentivizing politicians to adapt proposal rhetoric in response to a change in public attention to a problem. Using Kingdon's (1984) terminology, the adaptation in proposal rhetoric couples the policy stream with the problem stream. Focusing events increase public attention to a problem, motivating politicians to use rhetoric that describes the proposal as solving the problem the public wants solved after the focusing event. Without this change in proposal rhetoric, it is unlikely that the policy will be perceived as the solution to the problem of interest to voters after the event. Thus, focusing events motivate politicians to use policy proposal rhetoric that matches the problem garnering public attention because of the focusing event.

2.2.2 Political Attention and Proposal Design

I now shift to the second mechanism by which coupling occurs after a focusing event. Focusing events incentivize policy entrepreneurs to adapt policy proposal design to reflect the increased political attention to a problem after the event. Previously I defined political attention as the amount of interest in a problem from political actors. What is proposal design?

Policy proposal design is the content of a proposal. Schneider and Sidney (2009) explain policy design through the metaphor of a city's architecture: "just as the design of a city can be described along multiple dimensions – such as efficiency, esthetics, equality of access, adaptability, sustainability, friendliness, safety – so too can a policy design be evaluated according to a variety of dimensions" (104). The first step of policy design research is figuring out this architecture. Understanding the challenges in standardizing policy design research

without an understanding of the elements of policy's design, Schneider and Ingram (1997) offer a nine item framework.[20] The authors emphasize that all of the elements are empirically measurable and, depending on a researcher's goals, she may select one, multiple, or all of the items to investigate.

Policy entrepreneurs, the people around government who generate, design, and write legislation, choose from various options when designing a policy proposal. Kingdon (1984) calls this process alternative specification, or the process by which policy entrepreneurs hammer out the details of a policy proposal by selecting among the many possible elements for a policy's design. For example, in response to rising opioid overdose deaths, policy entrepreneurs may design proposals that increase punitive sanctions for drug-related crimes. Alternatively, they may design proposals that strengthen treatment for opioid addiction and enhance access to overdose prevention measures. Policy entrepreneurs may design policy proposals to create new programs that are nationwide and permanent or geographically limited and temporary. Further, they may allocate no money, some, or a lot to implement the program. All these features represent choices policy entrepreneurs make when designing a policy proposal.

Researchers have made great strides in understanding how and why we get certain policy designs, and the consequences of different designs. A variety of processes influence these design choices, including "political and social values, historical precedent, (and) national trends in ideas about "good" policy" (A. Schneider and Sidney 2009, 105). While studies differ in the factors examined (Baumgartner and Jones 1993; Bell 2021; Blanton and Jones 2023; Boushey 2016; Cobb and Elder 1983; Donovan 2001; Kingdon 1984; Stone 1989), a commonality among "those

[20] The nine elements of policy design are (1) problem definition and goals to be pursued; (2) benefits and burdens to be distributed; (3) target populations; (4) rules; (5) tools; (6) implementation structure; (7) social constructions; (8) rationale; and (9) underlying assumptions.

writing about policy design is the emphasis on matching content of a given policy to the political context" (May 1991, 188–89). For instance, one of the most well-known policy design frameworks contends that politicians design policies in line with the electoral consequences of awarding or sanctioning target populations according to their stereotypes and political power (Schneider and Ingram 1993, 2005).[21]

I continue this line of research by examining how focusing events affect policy proposal design. In addition to increasing public attention, focusing events heighten political attention to a problem among politicians across and within parties. This increase in attention occurs among politicians who were already interested in the problem, for instance, by encouraging them to release more statements related to the issue or making the issue their legislative priority. In addition, focusing events increase political attention to a problem among politicians who were uninterested in or did not prioritize the problem before the event.

Focusing events motivate policy entrepreneurs to adapt proposal design to reflect this increase in political attention after the event. Specifically, these events incentivize policy entrepreneurs to modify proposal design to reflect the politicians, and their partisan and ideological preferences, newly interested in the issue following the focusing event. Accommodating the preferences of these new coalition members attentive to the problem may distance the proposal from the priorities of politicians interested in the problem before the focusing event. However, these politicians were already invested in the problem. Consequently,

[21] In a series of articles beginning in 1988, the authors developed a theory that the target population of a policy design is not only selected because of its political power or objective policy need but also because of its social construction: value-laden stereotypes about groups as deserving or unworthy of benefits or punishments. They coin policy designs that benefit "liked" groups and sanction "disliked" groups congruent because they provide benefits and sanctions to recipients in ways that align with the target population's popular stereotypes and political power. Non-congruent policies, on the other hand, reward and punish in ways that contradict stereotypes and political prowess. Politicians prefer congruent policy designs over non-congruent alternatives because the former engenders political capital that can be used in future elections while the later invites political controversy (Ingram and Schneider 1990, 1991; Schneider and Ingram 1988, 1993; Schneider, Ingram, and Deleon 2014).21

they are likely willing to “give something up” to ensure the passage of a proposal addressing the issue. Thus, policy entrepreneurs have a greater incentive to adapt the proposal’s design to accommodate the individuals newly interested in the problem than the members already attentive to the issue before the focusing event. Using Kingdon's (1984) terminology, this adaptation in proposal design aligns the policy stream with the politics stream.

One may be surprised that I do not suspect increased public attention to a problem after a focusing event impacts policy proposal design (see Figure 2.2). This is because there is a cost associated with policy entrepreneurs adapting their policy proposals. Indeed, policy entrepreneurs possess an interest in not modifying their proposal’s design. They likely designed their proposals to align with their expertise in a policy area and do not want to change the content in response to the whims of public and political attention. Thus, for a policy entrepreneur to adapt their proposal’s design, there must be a good reason. Policy entrepreneurs change proposal design in response to increased political attention to a problem following a focusing event because politicians may obstruct a policy proposal’s passage because of its content. Politicians have strong policy design preferences and may block a policy proposal from becoming law if it does not align with these preferences. The public, on the other hand, is relatively uninformed about the details of politics (Carpini and Keeter 1996; Converse 1964), including policy specific knowledge (Gilens 2001). Thus, the public will likely not play a role in derailing a policy proposal from being enacted because of its design. Consequently, policy entrepreneurs are incentivized to change policy design in response to a change in political attention but not public attention.

In summary, focusing events heighten public and political attention to a problem, so much so that the problem becomes a priority issue among members from both parties

representing a range of ideological orientations. These events incentivize political actors to engage in coupling, whereby they adapt an existing policy proposal to match the problem and political environment after a focusing event. In the previous two sections, I provided a granular explanation of what happens during this coupling process. First, focusing events motivate politicians to adapt proposal rhetoric to reflect the increase in public attention to the problem. Second, these events incentivize policy entrepreneurs to adapt policy proposal design to accommodate the increased political attention to the problem after the event. Specifically, policy entrepreneurs are interested in modifying the proposal's design to reflect the preferences of the new members of the coalition attentive to the problem following the focusing event.

2.3 The Role of Agenda Setters in Coupling

In the previous section, I expanded upon Kingdon (1984) by providing a granular explanation for what happens during the coupling process following a focusing event. But coupling "does not need to happen; nothing means that the three streams flow together" (Greer 2016, 423). Sometimes political actors adapt a policy proposal's rhetoric and design in response to a focusing event, rapidly increasing public and political attention to an issue, achieving coupling. Other times, no adaptation occurs, and coupling remains elusive. This leads us to the fundamental question of my dissertation: while all focusing events incentivize the coupling process, why do some focusing events lead political actors to engage in coupling and others do not?

I argue that *agenda setters* hold the keys to the ignition of the coupling process because of their influence over the legislative agenda. Agenda setters are lawmakers who occupy positions that possess "special agenda setting powers," such as determining the legislation considered on the floor and under what procedures, that allow them to greatly influence which

bills arrive on the legislative agenda: the list of items actively being decided upon by Congress (Cox and McCubbins 2005, 9).[22] These agenda powers primarily belong to a small subset of lawmakers within the majority party, including committee and subcommittee chairs, the members of the Rules Committee, and the majority leader. The lawmakers occupying these positions can use these agenda controls to prevent undesirable legislation from reaching the floor (negative agenda control) or expedite bills to a vote (positive agenda control), providing them substantial control over which bills advance through the legislative process (Campbell, Cox, and McCubbins 2002; Cox and McCubbins 2005; Jenkins and Monroe 2016).

Why would the agenda setting powers of these lawmakers impact when focusing events lead to coupling? The objective of coupling after a focusing event is to adapt a policy proposal to reflect the problem capturing public and political attention following the event. By doing this, political actors increase the likelihood that a proposal will become one of the few items politicians actively make decisions about. But this adaptation does not occur in a vacuum. Rather, as described in the previous paragraph, members of the majority party who have control of the legislative agenda are the gatekeepers to this decision point; their agenda powers significantly influence which bills are voted upon and which bills stagnate in committee. I argue that the political actors responsible for coupling judge the likelihood of support for policy change among lawmakers occupying these agenda setting positions when deciding whether to engage in coupling. Support from agenda setters is critical to the decision to initiate coupling because it signals that these lawmakers are unlikely to use their agenda powers to block the coupled policy

[22] I note, like others, that agenda power differs from agenda control. I borrow Jenkins and Monroe's (2016) distinction: "Agenda power is the abstract ability to affect the agenda, whether actualized or not. Agenda control is the manifested results of actual attempts to affect the agenda" (158). I am more interested in agenda power, which encapsulates perceptions about the ability of the majority party to control the legislative agenda, as opposed to the actual control they possess.

from reaching the floor. Without this support, I expect that political actors choose not to engage in the coupling process.

Kingdon (1984) acknowledges how factors existing in the political stream influence coupling. But he does not closely examine how the power to set the agenda influences when political actors initiate coupling. Put another way, even though the goal of coupling is to prioritize a bill on the agenda, and a small subset of majority party lawmakers have disproportionate influence over this agenda, Kingdon (1984) minimizes the role of agenda setting in coupling. I add this feature to his seminal work through the argument outlined below.

I expect that judgments about how agenda setters will use their controls over a bill's progression explain why some focusing events initiate the coupling process and others do not. The coupling process is costly, and political actors will only take on these costs if they promise public policy benefits. Focusing events lead to coupling through two mechanisms – both associated with costs. First, in response to a focusing event increasing public attention to a problem, politicians are incentivized to adapt proposal rhetoric to align with the problem capturing public attention. This process requires politicians and their staff to spend resources designing and releasing new materials. Second, in response to a focusing event heightening political attention to a problem, policy entrepreneurs are motivated to adapt the proposal design to match new political attention to the problem. But policy entrepreneurs possess an interest in not modifying their proposal's design. They likely designed their proposals to align with their expertise in a policy area and do not want to change the content in response to the whims of public and political attention. Further, any change in proposal design likely undergoes a negotiation process that is resource intensive. Simply, the coupling process is not without costs.

Given these costs, political actors will engage in the coupling process if it portends public policy benefits. When lawmakers occupying the agenda setting positions relevant to a bill support the policy proposal before or at the onset of coupling, for instance, through sponsorship or rhetoric, these benefits outweigh the costs. Indeed, the political actors responsible for coupling predict that these agenda setters are unlikely to use their agenda powers to block the coupled policy from reaching the floor. However, suppose these agenda setters display no support for the policy. In that case, political actors will refrain from engaging in coupling, as there is no signal that the agenda setters and their agenda controls will not hinder a floor vote.

Taken together, I argue that agenda setters because of their control over a coupled bill's advancement play a crucial role in the decision to engage in coupling after a focusing event. Focusing events initiate the coupling process when political actors judge that relevant agenda setters will ensure the gates guarding the floor are open to the policy proposal after the coupling process. However, political actors will not engage in coupling after a focusing events if these agenda setters will use their agenda control to prevent the coupled policy from progressing to the floor.

2.4 Mass Shootings and Community Mental Health

Thus far, this chapter has defined the main theoretical variables embedded within a general question: why do some focusing events lead to coupling while others do not? First, I defined a focusing event as a rare and sudden event that rapidly increases public and political attention to a problem, so much so that the problem becomes a priority issue. Second, I explained that all focusing events incentivize coupling by providing a problem that political actors can hook to their policy proposal. I also detailed the mechanisms involved in the coupling process after a focusing event. Specifically, coupling involves political actors adapting proposal rhetoric

and design to align with the problem garnering public and political attention after the event. Finally, I outlined my argument, answering, despite all focusing events incentivizing the coupling process, why only some lead political actors to engage in coupling while others do not. I argued that political actors initiate coupling when they anticipate that agenda setters will not use their controls over the coupled bill's progression to block the adapted legislation from advancing through the legislative process.

The rest of this dissertation applies these general variables and argument to answer my fundamental question: why did school mass shootings in Newtown and Uvalde catalyze a coupling process that led to the most substantial reforms in community mental health policy in 30 years, but the shooting in Parkland did not?

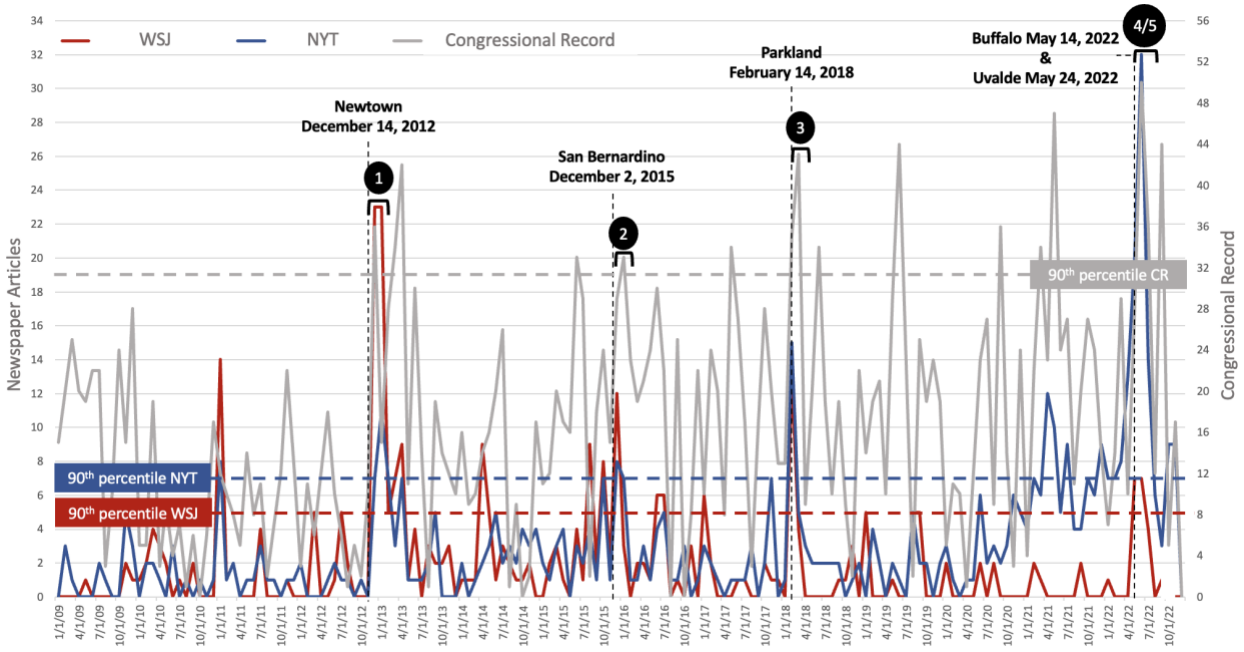
To apply this argument, I must first defend that the three mass shootings examined in this dissertation were focusing events. Many other mass shootings occurred between 2009 and 2022.[23] Figure 2.3 operationalizes a focusing event as mass shootings that triggered a month where the number of news articles and Congressional Record statements containing mentions of both "mental illness" and "violence" was in the 90th percentile for all months between January 2009 and December 2022.[24] The five mass shootings that meet this definition occurred in Newtown, Connecticut in December 2012; San Bernardino, California in December 2015;

[23] While the list would be too long if only one shooting were included, other mass shootings that do not meet my definition of a focusing event include those listed in Appendix A, such as the shootings at Route 91 Harvest music festival in Las Vegas, NV on October 2, 2017 where 58 were killed and 546 were injured; Pulse Nightclub in Orlando, FL on June 12, 2016 where 49 were killed and 53 were injured; and First Baptist Church in Sutherland Springs, TX on November 5, 2017 where 26 were killed and 20 were injured. It is not in the purview of this dissertation to answer why some mass shootings are focusing events and others are not. I am interested in how a mass shooting leads to the coupling or adaptation of community mental health policy proposals. However, I encourage future researchers to explore this question.

[24] Please see Appendix B for a discussion of how I distinguished mass shootings that were focusing events from other mass shootings.

Parkland, Florida in February 2018; Buffalo, New York in May 2022; and Uvalde, Texas in May 2022.

Figure 2.3: Mass Shootings That Were Focusing Events



Note: WSJ: Wall Street Journal. NYT: New York Times. CR: Congressional Record. I identified news articles using the following search strategy. In the New York Times and Wall Street Journal Databases in ProQuest News & Current Events, I searched the following text string: ("mental illness" OR "mental health") AND ("violence" OR "violent" OR "gun" OR "shooting"). I limited the search to anywhere in the article except the full text, meaning that the search included the title, abstract, subject, and other summary. I further limited the search by excluding articles with a source type other than "Newspaper" and articles not written in English. I identified statements in the Congressional Record by searching the same text string in the Congressional Record search of congress.gov.

I decide to exclude the San Bernardino and Buffalo focusing events from my analysis because they differ in important ways from the Newtown, Parkland, and Uvalde shootings. The Newtown, Parkland, and Uvalde shootings share many features, including that all three focusing events occurred at schools and were perpetrated by male, former students. San Bernardino and Buffalo differed from these events. San Bernardino involved a mass shooting, resulting in the deaths of 14 and an attempted bombing by a U.S. born Pakistani man and a female Pakistani green card holder at a center that provides services for persons with developmental disabilities. The Buffalo shooting involved a white shooter murdering 10 black people at a supermarket.

Given these shooting profile differences, I limit my analysis to the Newtown, Parkland, and Uvalde shootings.

Since all three mass shootings were focusing events, each event incentivized political actors to engage in coupling community mental health policy proposals with the problem garnering attention after the event. At the time of each mass shooting, policymakers had identical or similar transformational community mental health policy proposals ready for adaptation Before the shooting in Newtown, legislators had introduced the Excellence in Mental Health Act, which created a new community mental health provider and a new program to financially support the establishment and maintenance of the CCBHC program. Before the Parkland and Uvalde focusing events, lawmakers had introduced the Excellence in Mental Health and Addiction Treatment Expansion Act, which expanded the reach of the CCBHC program by adding more locations and extending the program's expiration date.

Each focusing event incentivized the coupling of this proposal with the problem prioritized by the focusing event – mental illness allegedly causing violence – through two mechanisms. First, each mass shooting incentivized politicians to adapt policy proposal rhetoric in response to increased public attention to a problem, so the proposal became the perceived solution to the problem of mental illness allegedly causing violence. Second, the mass shootings also incentivized policy entrepreneurs to adapt policy proposal design in response to heightened political attention to a problem. This design adaptation accommodates the public policy preferences of the politicians newly attentive to the problem after the mass shooting. Through these two adaptations, political actors increase the likelihood of achieving a coupled community mental health policy proposal – a politically feasible proposal perceived as the solution to the

problem capturing attention after the focusing event – likely placing it at the top of the legislative agenda.

However, political actors only engaged in coupling community mental health policy proposals after Newtown and Uvalde, not Parkland. Indeed, politicians adapted their proposal rhetoric and design after Newtown and Uvalde but made no such adaptations after Parkland. This is particularly surprising given that the three mass shootings shared similar problem, policy, and political contexts. As discussed previously, each shooting occurred at a school and was perpetrated by a male former student. At the time of each mass shooting, lawmakers had introduced similar, substantial community mental health policy proposals – the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act – available for adaptation. Further, before or immediately after each school shooting, the same bipartisan champions, Senators Blunt (R-MO) and Stabenow (D-MI) and Representatives Matsui (D-CA) and Lance (R-NJ), led a bipartisan coalition of lawmakers sponsoring the Excellence in Mental Health Act or Excellence in Mental Health and Addiction Treatment Expansion Act.

The rest of this dissertation defends my argument that agenda setters – because of their controls over which bills advance through the legislative process explain – why coupling occurred after Newtown and Uvalde but not Parkland. The agenda setters relevant to mental health policy at the time of Newtown and Uvalde displayed support for the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act through sponsorship and rhetoric. Consequently, the political actors responsible for coupling judged that agenda setters would not prevent the adapted proposal from progressing through the legislative process. In contrast, the lawmakers in relevant agenda setting positions at the time of Parkland never communicated support for these community mental health policy proposals.

Without this support, political actors had no information to suggest that agenda setters would not use their controls to block the coupled policy from a vote, disincentivizing the coupling process. Ultimately, this difference in support from agenda setters contributed to why Newtown and Uvalde produced coupling and significant community mental health policy reforms while Parkland did not.

2.5 Alternative Explanations

Other frameworks may explain the decision to engage in coupling after a mass shooting. In this section, I describe these potential alternative explanations, focusing on the potential role of interest groups and the presidency and mentioning other variables that might contribute to the variation in coupling after Newtown, Parkland, and Uvalde. Importantly, I view these frameworks as complementary to my theory that judgments about how agenda setters will use their controls over bill advancement explain the decision to initiate the coupling process.

I begin with the potential role of interest groups. Several interests occupy the policymaking space that resides at the intersection where mental health policy meets gun policy. This includes mental health organizations, such as the National Council for Mental Wellbeing, which is the advocacy and lobbying organization representing community mental health centers nationally. Other groups are those that support additional gun control, including United Against Gun Violence, Moms Demand Action, and Everytown for Gun Safety, and those against, namely the National Rifle Association (NRA), whose substantial influence in Washington and state capitals is well documented by political science and public policy scholars (Fleming et al. 2016; Gross 2006; Lacombe 2021; Reich and Barth 2017).

Features of this pluralistic policy space may explain the differences in coupling after Newtown, Parkland, and Uvalde. Specifically, variation in the distribution of the lobbying

activities and resources of these many interest groups may explain why political actors engaged in coupling after Newtown and Uvalde but not Parkland. For instance, the NRA may have promoted community mental health reforms among lawmakers after Newtown and Uvalde but elected another strategy after Parkland. Perhaps the National Council for Mental Wellbeing was focused on another policy or otherwise occupied following Parkland, minimizing their lobbying activities related to community mental health, but after Newtown and Uvalde, they were unilaterally focused and devoted substantial resources to pursuing these reforms. Thus, the activities of interest groups may explain the decision to engage in coupling a community mental health policy with the problem of mental illness allegedly causing violence after a mass shooting.

Characteristics of the president, specifically presidential preferences for the status quo mental health policy, may also contribute to the variation in coupling after Newtown, Uvalde, and Parkland. Donald Trump occupied the presidency when Parkland occurred on February 14, 2018. President Trump may have favored maintaining the status quo mental health policy. This inaction does not require policy activity, providing Republican lawmakers no incentive to focus limited legislative attention, including the activities involved in coupling, on a policy that expands mental health treatment after a mass shooting. In contrast, the president in office in December 2012, when Newtown occurred, was Barack Obama and the president in May 2022, at the time of Uvalde, was Joe Biden. These Democratic presidents may have strongly supported policies that expand mental health treatment. Moving the status quo policy toward their policy ideal requires policy activity, including negotiation and compromise, because these bills are unlikely to pass without Republican support. Consequently, coupling may have ensued after Newtown and Uvalde because lawmakers responding to presidential preferences for mental health policy expansions had to adapt legislation so that they migrated toward Republican policy

preferences. Thus, these potential differences in presidential preferences for mental health policy may explain the decision to engage in coupling after Newtown and Uvalde but not Parkland.

Importantly, these potential alternative explanations do not eliminate my theory that agenda setters were crucial to the decision to initiate coupling after the three mass shootings examined in this dissertation. Rather, it is a complementary theory. Regardless of the lobbying activities of interest groups or the president's mental health policy preferences, the actors involved in coupling are still incentivized to consider the preferences of legislators with agenda setting powers. When deciding whether to spend resources on the coupling process, political actors judge whether the resource costs are worth the public policy benefits of coupling, including the likelihood that agenda setters will block the coupled bill from reaching the floor. This is an essential consideration explicitly because the goal of coupling is to increase the probability that a bill reaches a decision point, and the agenda setters are the gatekeepers to this decision point. Thus, interest group activities and presidential preferences do not eliminate the incentive to consider how agenda setters may use their agenda controls on the coupled policy. Indeed, one can think of these alternative explanations as additional considerations, not a replacement for the motivation to predict agenda setter preferences toward the hypothetical coupled policy.

Moreover, it is also possible that the effect of these other variables on coupling is mediated by my explanatory factor: judgements about how agenda setters will use their controls over the coupled bill's advancement. The activities of interest groups and presidential preferences may explain why agenda setters offer legislative support before the coupling process begins. For instance, the NRA or the president may have lobbied the lawmakers occupying relevant agenda setting positions to provide signals of support indicating that the coupled bill

would advance through the legislative process. Thus, if these alternative explanations are valid, meaning that they contributed to the coupling outcome after Newtown, Parkland, and Uvalde, it may be through a mediation with the argument defended in this dissertation.

In addition to the role of interest groups and the president, other factors may contribute to the decision to engage in coupling of a mental health policy after a mass shooting. For instance, perhaps the trigger to the coupling process differed in the three cases examined here. In the theory of punctuated equilibrium, Baumgartner and Jones (1993) describe the concept of positive feedback as a self-reinforcing process whereby a series of small events amplify the effects of downstream events, explaining some sudden radical policy changes dispersed in between long periods of incremental policymaking. Positive feedback may characterize the periods before Newtown and Uvalde but not Parkland, suggesting that differences in the catalyst explain when political actors act on incentives to engage in coupling. I find this alternative unlikely, given that all three events dramatically heightened attention to the problem of mental illness allegedly causing violence to similar levels. Another potential explanation relates to the attributes of the social movements following each mass shooting. The faces of the movement advocating for policies that expand gun control differed after Newtown and Uvalde compared to Parkland. The Newtown and Uvalde advocates were the parents of the children killed, whereas the Parkland advocates were the students at the school where the shooting occurred. This difference in the characteristics of the advocates may also have contributed to the decision to engage in coupling after Newtown and Uvalde but not Parkland. Again, I find this alternative improbable since the shooting profiles shared many other characteristics, and the same interest groups likely occupied the policy space at the intersection of mental illness and gun violence after each mass shooting.

While I do not empirically examine any of these alternative explanations in my dissertation, I outline them here for two reasons. First, I bring attention to these frameworks to identify opportunities for future investigation. Second, and more importantly, I highlight why these other explanations fail to eliminate my argument that the decision to engage in coupling after a mass shooting depends on judgments about agenda setters and their use of their agenda controls. The rest of this dissertation defends this argument.

Chapter 3 Trends in Rhetoric Describing Community Mental Health Policy

The objective of this dissertation is to examine why the Newtown and Uvalde mass shootings led political actors to engage in the coupling of community mental health policy with the problem of mental illness causing violence, while a similar shooting in Parkland did not affect the adaptation of an identical proposal. However, before answering this question, I must defend my argument that political actors pursued coupling after Newtown and Uvalde but not Parkland. This chapter begins to answer this question.

Previously, I defined coupling as the process by which political actors adapt a policy proposal to become the perceived solution to the problem prioritized by the focusing event in a way that is amenable to the political environment. Applying this definition to the cases examined in this dissertation, the shootings examined here motivated political actors to couple existing community mental health policy proposals with the problem garnering public and political attention after each event: mental illness allegedly causing violence. I argued that this coupling process involved two mechanisms. First, the Newtown, Parkland, and Uvalde shootings incentivized politicians to adapt community mental health proposal rhetoric to reflect the increase in public attention to the problem of the perceived relationship between mental illness and violence. In addition, the mass shootings motivated policy entrepreneurs to modify community mental health proposal design to accommodate the new political attention to this problem. The mass shootings encouraged both proposal adaptations because they serve different purposes. Adaptations in policy proposal rhetoric by politicians align the community mental

health proposal with the problem capturing public attention after the shooting. Adaptations in policy proposal design by policy entrepreneurs align the proposal with the new political coalition attentive to the problem of mental illness allegedly causing violence after the focusing event.

Putting aside the role of policy entrepreneurs in adapting proposal design in response to heightened political attention to a problem, this chapter examines the relationship between public attention to a problem and proposal rhetoric. Public attention is the amount of public interest in a problem, for instance, the amount of media coverage or social media posts about an issue. Proposal rhetoric is the way politicians describe a policy proposal. The Newtown, Parkland, and Uvalde mass shootings encouraged politicians to adapt rhetoric describing existing community mental health proposals to align with the problem garnering public attention after the event – mental illness allegedly causing violence – because this rhetorical shift would attach the proposal as the solution to the problem. This chapter answers whether this shared incentive across all three mass shootings led politicians to adapt their rhetoric related to community mental health policy.

Specifically, I examine whether lawmakers modified their rhetoric describing similar, substantial community mental health policy proposals on the legislative docket at the time of each school shooting. The Excellence in Mental Health Act – introduced seven times before the shooting at Sandy Hook Elementary School on December 14, 2012, including six months prior to the shooting – created a new type of community mental health provider, certified community behavioral health centers (CCBHCs), and a program to financially support the establishment and maintenance of the CCBHC program. The bill would become the first significant federal community mental health policy reform in thirty years. The Excellence in Mental Health and Addiction Treatment Expansion Act – introduced five times before the shooting in Parkland, Florida on February 14, 2018, including four months prior, and ten times before the shooting in

Uvalde, Texas on May 24, 2022, including two months prior – expanded the CCBHC program by adding more locations to and increasing the length of the program. This chapter examines whether the Newtown, Parkland, and Uvalde mass shootings changed how lawmakers discussed these policies.

My methodological approach applies content analysis of two types of political statements – press releases and floor remarks – to capture the rhetoric used by lawmakers to describe community mental health policy proposals between 2009 and 2022, resulting in an analysis of over 555 political statements. I present my analysis using aggregate trends to illustrate systematic shifts in how politicians talk about community mental health policy proposals. Indeed, the reader will leave this chapter with convincing empirical evidence demonstrating that politicians strategically adapt their use of violence rhetoric describing community mental health policy proposals.

Politicians increased their use of violence rhetoric in response to some mass shootings but not all. Following Newtown and Uvalde, politicians substantially increased their use of violence descriptions of community mental health policy proposals. For instance, descriptions implying that community mental health policy proposals were necessary to improve the mental health treatment system so that it intervenes before "someone does something that tragically impacts their lives and the lives of others" (Blunt 2013a). Put another way, "…in the absence of timely diagnosis, early intervention, and treatment, people experiencing illness are at risk of committing acts of violence — at a rate 15 times higher than those in treatment" (Leahy 2013). However, the mass shooting in Parkland did not affect the prevalence of violence rhetoric used by politicians to describe community mental health. Violence descriptions constituted 0.0% of all references six months before and after Parkland.

Taken together, this chapter establishes that the Newtown and Uvalde shootings led lawmakers to engage in at least one of the two mechanisms involved in coupling after a focusing event. After these mass shootings, politicians used substantially more violence rhetoric to describe community mental health policy proposals, including the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act. This rhetorical adaptation facilitated the attachment of community mental health policy proposals to the problem garnering public attention after the event: mental illness allegedly causing violence. In contrast, after Parkland, politicians did not adapt their rhetoric describing community mental health policy proposals to align with this problem, demonstrating that politicians did not engage in the rhetorical mechanism of the coupling process after this school shooting.

3.1 Text Corpus

The objective of this chapter is to examine whether politicians adapted their rhetoric describing similar, substantial community mental health policy proposals after mass shootings in Newtown, Parkland, and Uvalde that raised public attention to the problem of the perceived relationship between mental illness and violence. But where does this rhetoric exist? A politician releases many forms of political statements, such as speeches, interviews, and campaigns, that provide space for her to describe a policy proposal. I select two types of political communication – press releases and floor remarks – to capture proposal rhetoric.

Both press releases and floor remarks are ideal for examining proposal rhetoric because they contain a politician's unfiltered expressed agenda. The expressed agenda embodies how a politician communicates her priorities to her constituents, not necessarily how she distributes her resources in Washington (Grimmer 2010). It is essential to capturing how politicians describe policy proposals because it contains how a legislator chooses to present a policy proposal.

Indeed, lawmakers shape understandings of policy proposals through credit claiming or expressions of opposition (Grimmer, Westwood, and Messing 2015; Mayhew 1974). For instance, a lawmaker sponsors a bill to increase access to substance use disorder treatment in the Veterans Administration. The legislator issued a press release describing the problem solved by the legislation as veterans who became addicted to prescription opioids following treatment for an injury resulting from his time in service. However, the lawmaker had alternative rhetorical choices available. Instead, she could have framed the problem as veterans with any substance use disorder, veterans who have overdosed, or veterans who use methamphetamines or alcohol. However, describing the policy proposal as addressing veterans who use prescription opioids because of a service-related injury signals that the politician perceived that her constituents would reward her electorally by addressing this problem instead of the alternative frames.

I select press releases and floor remarks because these types of political communication contain an unfiltered version of the expressed agenda. Some mediums have a filtered version of this agenda, meaning another source describes how a politician communicates her activities instead of exclusively containing the politician's descriptions. A common version of this filtered expressed agenda exists in the media. Newspaper articles, podcasts, and television news summarize a politician's activities and his rhetoric used to describe those activities. Through this editing, the media entity applies its lens to the politician's description, making it challenging to distinguish how the politician describes policy proposals from how the media portrays the politician's description of the policy proposal (Grimmer 2010; Sulkin 2005). For this reason, I elect two types of political communication that are unfiltered: floor statements and press releases released by lawmakers. Legislators directly communicate to their constituents

through these mediums, ensuring that my analysis captures the rhetoric used by politicians to describe a policy proposal.

Some may argue that the average constituent does not regularly consume their representative's floor remarks or press releases, refuting my argument that these mediums aim to shape constituency preferences through descriptions of a policy proposal. However, the content of these statements still reaches the public regardless of whether an individual voter reads a press release or listens to a floor statement. Grimmer (2013) shows that local papers engage in what he coins ventriloquism, where local media print text verbatim from press releases. Through this mechanism, lawmakers still use floor remarks and press releases to reach voters even if a constituent does not directly engage with the statement. Consequently, I expect that these forms of political communication contain the rhetoric used to describe a policy proposal that lawmakers hope will influence voter preferences in ways that will provide individual and collective political rewards.

While both floor remarks and press releases contain the unfiltered expressed agenda, I elect to analyze both because of differences in the time constraints associated with producing a statement.[25] Press releases are immune from many time constraints imposed on floor remarks.

[25] I also elect to examine floor remarks and press releases because of a methodological limitation described in detail in Appendix C. While I capture the universe of floor remarks mentioning community mental health between January 1, 2009 and July 31, 2022, my press release dataset is limited to press releases issued by lawmakers who served in the 117th Congress (2021-2022). This constraint results from the location of my search: .gov websites. Formerly serving public officials do not maintain their .gov website upon leaving their position, so I cannot access press releases from senators not actively in public office. Consequently, my dataset contains 39 of the senators in the 111th Congress (2009-2010), 51 of the senators in the 112th Congress (2011-2012), 63 of the senators in the 113th Congress (2013-2014), 74 of the senators in the 114th Congress (2015-2016), 80 of the senators in the 115th Congress (2017-2018), 91 of the senators in the 116th Congress (2019-2020), and the 100 senators of the 117th Congress (2021-2022). In Appendix C, I address this limitation in two ways. First, I stratify the results presented in this chapter by floor remarks and press releases. Since my data contains the universe of floor remarks mentioning community mental health, if the proportion of press releases with a description resembles that of the floor remarks, I assume that the data contain accurate prevalence rates. Second, I compare the proportion of Democratic and Republican senators in my sample to the party distribution among the population of senators in office for each Congress. The prevalence of Democratic and Republican senators in my sample resembles the proportion of

Given that the time of debate is controlled in the House (by the adopted rule) and the Senate (by unanimous consent agreement), the lawmakers who speak on an issue during bill consideration tend to be those with the greatest interest in the legislative matter. Most frequently, these individuals are sponsors of the bill or amendment. Press releases published on a legislator's website, however, and unlike forms of paid engagement (e.g., television ads, mailers), provide near limitless space for individuals to release statements. There are also nearly no formal restrictions on a statement's content (Druckman et al. 2010; Grimmer and Stewart 2013). This permits legislators to remark on topics that may be too costly to discuss in other contexts, including on the Senate or House floor. Nonetheless, while the bar is lower than for many other forms of political communication, a strategic politician will still consider an issue's saliency, prioritizing issues that will benefit him electorally and minimizing issues with perceived repercussions (Mayhew 1974). Thus, legislators who perceive some but not substantial political rewards with a statement are more likely to release a press release than make a floor remark because of the lower costs. Consequently, by including press releases, I add more lawmakers and statements to my analysis than if I limited my study to the Congressional Record.

Methodologically, coding press releases and floor remarks related to community mental health also addresses a challenge plagued by many researchers interested in analyzing text data: volume. While political scientists have long appreciated that "much of politics is expressed in words" (Grimmer and Stewart 2013), manual textual analysis is time consuming and expensive. Compared to other text data, like speeches and party platforms, press releases are typically short texts communicating the issue frames most important to the legislator. Further, the Congressional

Democrats and Republicans in office for each Congress. Thus, the party makeup in my sample does not differ substantially from the Senate partisan distribution for each Congress. Therefore, if my assumption holds that Democratic and Republican senators use rhetoric in ways like their party peers, my sample should reflect the prevalence of topics throughout my study period.

Record on community mental health is limited, making manual coding feasible. Thus, by limiting my corpus to press releases and the Congressional Record, I have the bandwidth to manually analyze text data and capture trends in rhetoric related to community mental health policy proposals.

3.2 Methodological Approach

As a reminder, the objective of this chapter is to examine whether politicians engaged in the rhetorical component of coupling community mental health policy proposals following mass shootings in Newtown, Parkland, and Uvalde. Each of these shootings heightened public attention to the problem of mental illness allegedly causing violence, incentivizing politicians to adapt their rhetoric describing existing community mental health proposals to align with this problem. Specifically, at the time of each event, lawmakers had recently introduced substantial community mental health policy proposals – the Excellence in Mental Health Act and the Excellence in Mental Health Addiction Treatment Expansion Act – that created or expanded a program to financially support a new community mental health provider. Did the incentive to adapt their rhetoric to align with the problem garnering attention after each mass shooting lead politicians to change how they described these community mental health policy proposals?

In this section, I provide an overview of my methodological approach to identify the evolution of community mental health proposal rhetoric or the ways politicians describe community mental health policy proposals. For a more detailed description, please refer to Appendix C. In summary, I conducted a manual content analysis of descriptions of community mental health policy proposals in press releases and floor remarks released by members of Congress between January 1, 2009 – July 1, 2022. This period captures all years when

lawmakers introduced a version of the Excellence in Mental Health Act or the Mental Health and Addiction Treatment Expansion Act.

I gathered press releases and floor remarks that discuss community mental health in the main text body.[26] For instance, I included statements that contain the following phrases: "community mental health," "community mental health care," "community behavioral health," "community behavioral health care," "community mental health clinic," or "community behavioral health clinic." I also include statements with phrases referencing the CCBHC model – the provider created through the Excellence in Mental Health Act and expanded by the Excellence in Mental Health and Addiction Treatment Expansion Act. In addition, I included documents that reference federal policies that exclusively contain provisions related to community mental health,[27] as well as statements discussing federal community mental health center programs.[28]

I operationalize community mental health policy proposal rhetoric as the topics present in the data. Like other researchers, topics are an ideal tool for examining policy proposal descriptions because they bring attention to a subset of the many concepts that may be present in a discussion. I identify these topics through a content analysis, which intends to locate words and themes in text data (Elkins, Spitzer, and Tallberg 2018; Elo et al. 2014; Hsieh and Shannon

[26] I gathered floor remarks in the House and Senate through a search in the "Legislation" function of congress.gov, selecting the options "include full text when available" and "word variants." I searched the following keywords: "community mental," "community behavioral," "community-based behavioral," "community based behavioral," "community-based mental," and "community based mental." To gather press releases, I searched the .gov website of senators in office on July 1, 2022 using the following keywords: "community mental health," "certified community behavioral health clinic," "CCBHC," "federally qualified behavioral health clinic," "federally-qualified community behavioral health center," "community behavioral," "community-based mental," and "community-based behavioral." Please see Appendix C for why limiting my text corpus only to senators in office on July 1, 2022 does not bias my sample.

[27] The only federal policy that exclusively applies to community mental health was the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act.

[28] Federal community mental health center programs were the Section 223 Medicaid Demonstration and SAMHSA Expansion Grant program.

2005). While some of the previous literature quantitatively identifies frames through structural topic models (Gilardi, Shipan, and Wüest 2021), my approach resembles Baumgartner et al.'s (2008) qualitative frequency analysis of newspaper abstracts related to the death penalty, in which the authors count the number of newspapers articles using a particular topic at a given time.

In line with the conventional approach to content analysis, I developed the coding scheme to identify these topics a priori and then revised it iteratively during a review of 10 percent of included press releases (Hsieh and Shannon 2005). An undergraduate student at the University of Michigan and I coded the political statements independently and met to discuss discrepancies until we reached an agreement.[29] Appendix E presents the coding scheme. Four distinct topics, or ways of describing the community mental health policy proposal, emerged in the data. Mental health is the first. This code contains any mention of mental illness, mental health, or the mental health care system. It also includes references to serious mental illness; specific mental health disorders, such as schizophrenia, depression, bipolar disorder, post-traumatic stress disorder, and anxiety; and crisis events, including suicide. The second topic is substance use: any reference to substance use or the care system involved in substance use disorder treatment. It includes discussions of substance use generally; specific substances, such as alcohol, opioids, or methamphetamines; and overdose and other substance use crisis events.

The third topic used to describe community mental health policy proposals is behavioral health, which includes discussions that explicitly use the phrase behavioral health or the behavioral health care system. Behavioral health is an amorphous category of mental health, substance use, and other disorders. For instance, the American Medical Association (2022)

[29] Skyler Edinburg, the undergraduate student who jointly coded the political statements, was an unparalleled research assistant, demonstrating the meticulousness, consistency, and entrepreneurialship of a seasoned researcher.

defines behavioral health as “mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms.” The Centers for Medicare & Medicaid Services (2022) characterizes behavioral health as inclusive of the emotions and behaviors that affect your overall well-being. Thus, behavioral health is an overarching term for conditions that fall within the narrower, yet still encompassing, categories of mental illness and substance use but may also include other disorders, such as autism and obesity.

The final description category is violence – the focus of this chapter. This category contains references to behaviors or events in which an individual or group harmed or may harm another individual or group. This means that I exclude references that discuss an individual harming herself. I code this as mental illness. Often descriptions discuss gun violence or mass casualty events. This category also includes discussions of violence prevention activities and policies, such as red flag laws, background checks, and references that explicitly link mental health, substance use, or behavioral health programs with violence prevention.

While these four ways of describing a policy proposal are distinct, I note that a single sentence may contain multiple codes. Here is an example: “our community mental health bill will help curb unprecedented rates of suicide and overdose deaths.” I code this sentence using mental health and substance use characterizations to capture mentions of suicide and overdose. Indeed, by using both codes, I gather that the politician describes the community mental health policy proposals as addressing both mental illness and substance use.

My analytical goal in this chapter is to identify trends in violence descriptions of community mental health policy proposals to assess whether politicians coupled these proposals with the problem of mental illness allegedly causing violence following mass shootings in Newtown, Parkland, and Uvalde. Consequently, I present most analyses as prevalence rates

measured as the proportion of statements that contain any violence description and the percent of descriptions that are violence.[30,31] The denominator for the proportion of descriptions measure is the sum of all descriptions in the document. For instance, a floor remark contains ten sentences with community mental health proposal descriptions. Five are mental illness, three are behavioral health, two are substance use, and ten are violence. The proportion of descriptions that are violence is 50.0%.

I examine the significance of changes in violence rhetoric describing community mental health policy proposals using χ^2 tests and t-tests. Specifically, I performed χ^2 tests of independence to compare the proportion of statements containing a violence description in year 1 to those in year 2, examining the null hypothesis that year has no association with violence as a proportion of statements, or p(year 1) = p(year2). If the number of statements in a year is less than 10, I applied the Fisher's exact test as a substitute for the χ^2 test of independence because it is better suited to small sample sizes (Kim 2017). For the proportion of descriptions, I used independent t-tests. I tested the null hypothesis that the mean difference in the proportion of violence descriptions between years is zero. All tests are two-tailed with significance determined at 0.05 level.

[30] I present proportions instead of numbers (e.g., the number of statements or sentences containing a description) for two reasons. First, I acknowledge that my decision only to include press releases issued by senators in office on July 1, 2022 implies that I may miss relevant press releases from senators excluded from the analysis. Thus, I cannot know whether my data reflect the number of descriptions present in statements. However, since my sample of senators issuing press releases for each Congress shares the same partisan distribution as that Congress, and the prevalence rates for violence descriptions in the press release data resemble that of the floor remarks (see Appendix C), I am confident that the proportions are accurate. Second, other health politics research relies on proportions as the primary statistic (Barry et al. 2011, 200; Kennedy-Hendricks et al. 2019). Thus, my approach follows convention in presenting results as the proportion of statements that mention a description.

[31] I present measures at the statement and reference levels to compare the prevalence of statements that contain a topic with the amount of text devoted to a specific issue. While the measure at the statement level conveys the proportion of statements that bring attention to a topic, it is a rather blunt measure of the amount of attention afforded to each description. The reference level measure, on the other hand, provides more granular insight on whether a description appears frequently or sporadically.

3.3 Results

This chapter aims to examine whether political actors engaged in one of the two mechanisms of the coupling process incentivized by focusing events like mass shootings. I answer the following: did politicians adapt their rhetoric describing community mental health policy proposals by using more violence descriptions to align the proposal with the problem garnering public attention after each event: mental illness allegedly causing violence? This section provides the empirical answer to this question. First, I describe the characteristics of my dataset, including the number of political statements and the partisan affiliations of the lawmakers releasing statements. In the next section, I put aside the Newtown, Parkland, and Uvalde mass shootings and describe the evolution of violence descriptions over time to determine whether there are any aggregate trends in violence rhetoric of community mental health policy proposals. In the final section, I examine whether politicians increased their use of violence rhetoric describing a community mental health policy proposal following these mass shootings.

3.3.1 Descriptive Characteristics

Table 3.1 presents the percentage of statements in my sample by source and party over time. Five hundred fifty-five statements met the inclusion criteria, including 125 floor remarks (22.5%) and 430 press releases (77.5%). Press releases made up the majority of statements in all years except 2009, 2010, 2011, and 2012 regardless of party. The number of statements in my sample increased with time. In 2009, lawmakers made six floor statements and did not issue a press release. In 2022, the number of floor remarks increased to 29, and the number of press releases increased to 77.

In addition, Table 3.1 illustrates four periods with distinct patterns in political communications related to community mental health. Between 2009 and 2012, there were very few statements. Indeed, in the first four years of the analysis, lawmakers issued a total of 14 statements. Following this period, there was a sharp increase in the number of statements from 2012 to 2013. The number grew to 32 in 2013 with senators issuing 19 press releases (59.4%) and lawmakers making 13 (40.6%) floor statements. Between 2014 and 2019, lawmakers issued a similar number of statements as they did in 2013 until a second surge began in 2020 and continued through 2022. The number increased from 39 in 2019 to 87 in 2020, 108 in 2021, and 106 in 2022. I observe this increasing trend in the press release data (2019: 34; 2020: 75; 2021: 104; 2022: 77) and the Congressional Record data (2019: 5; 2020: 12; 2021: 4; 2022: 29).

Table 3.1: Percent of Statements by Year, Source, and Party, Jan. 2009 – Jul. 2022

Period	Year	All			Democrat			Republican		
		All	CR	PR	All	CR	PR	All	CR	PR
		N	%	%	N	%	%	N	%	%
1	2009	6	100.0	0	6	100.0	0	0	-	-
	2010	6	66.7	33.3	5	60.0	40.0	1	100.0	0.0
	2011	4	100.0	0.0	3	100.0	0.0	1	100.0	0.0
	2012	4	100.0	0.0	4	100.0	0.0	0	-	-
2	2013	32	40.6	59.4	15	46.7	53.3	17	35.3	64.7
	2014	28	40.6	59.3	13	46.2	53.9	15	33.3	66.7
3	2015	45	20.0	80.0	22	27.3	72.7	23	13.0	87.0
	2016	32	34.4	65.6	9	33.3	66.7	23	34.8	65.2
	2017	26	26.9	73.1	15	40.0	60.0	11	8.3	91.7
	2018	37	16.2	83.8	27	18.5	81.5	10	9.1	90.9
	2019	38	13.2	86.8	22	9.1	90.9	16	18.8	81.3
4	2020	86	14.0	86.1	46	8.7	91.3	36	22.2	77.8
	2021	108	3.7	96.3	74	2.7	97.3	33	6.1	93.8
	2022	103	28.2	71.8	64	26.6	73.4	36	30.1	69.9
	All	555	22.5	77.5	325	22.8	77.2	222	22.5	77.5

Notes: CR = Congressional Record. PR = Press Releases.

3.3.2 Violence Policy Proposal Rhetoric, 2009-2022

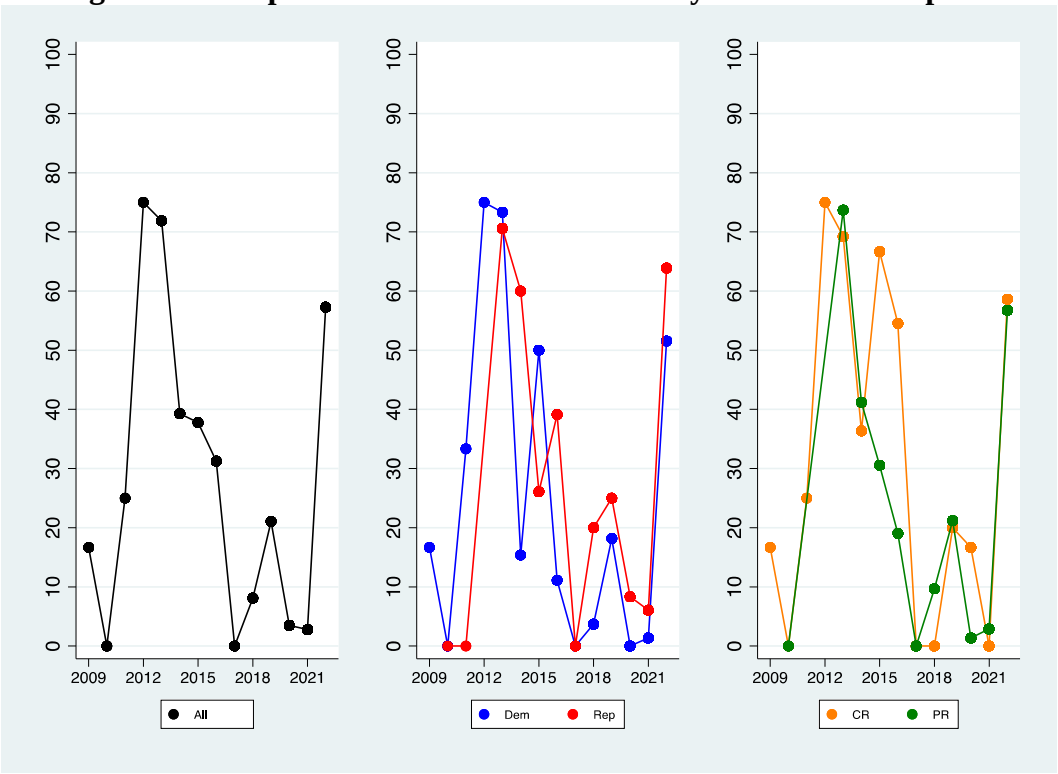
I now examine trends in the use of violence descriptions in political statements related to community mental health over time, putting aside when the Newtown, Parkland, and Uvalde mass shootings occurred. Figures 3.1 and 3.2 present this analysis, demonstrating that politicians changed their use of violence descriptions of community mental health policy proposals between 2009-2022. Specifically, there are four distinct patterns of violence rhetoric: two periods where violence frames exist in a large proportion of all statements and descriptions (2012-2013 and 2022), and two periods where violence frames make up a small proportion of all statements and descriptions (2009-2011 and 2014-2021).

I begin with Figure 3.1, which depicts the proportion of statements that use any violence description of a community mental health policy proposal. Put another way, a statement is counted as containing a violence description if it has 1, 3, or 10 references to violence. Figure 3.1 reveals that the percentage of statements that contain any reference to violence increased between 2011 and 2012, maintaining this increase through 2013. In 2011, 25.0% of statements used violence characterizations compared to 75.0% in 2012 and 71.9% in 2013. I observe this increase for Democratic (2011: 33.3%; 2012: 75.0%; 2013: 73.3%) and Republican (2011: 0.0%; 2012: 0.0%; 2013: 70.6%) statements and for floor remarks (2011: 25.0%; 2012: 75.0%; 2013: 69.2%), and press releases (2011: 0.0%; 2012: 0.0%; 2013: 73.7%).

After 2013, when the percentage of statements with any violence description was 71.9%, the proportion decreased sharply to only 2.8% or statements ($p<0.01$). This reduction existed for statements issued by Democratic (2013: 73.3%; 2021: 1.35%; $p< 0.01$) and Republican (2013: 70.6%; 2022: 6.06%; $p< 0.01$) lawmakers. It also remained in analyses limited to press releases

(2013: 73.7%; 2021: 2.9%; p< 0.01) and the Congressional Record (2013: 69.2%; 2021: 0.0%; p<0.01).

Figure 3.1: Proportion of Statements With Any Violence Description



Note: CR = congrssional record; PR = press releases.

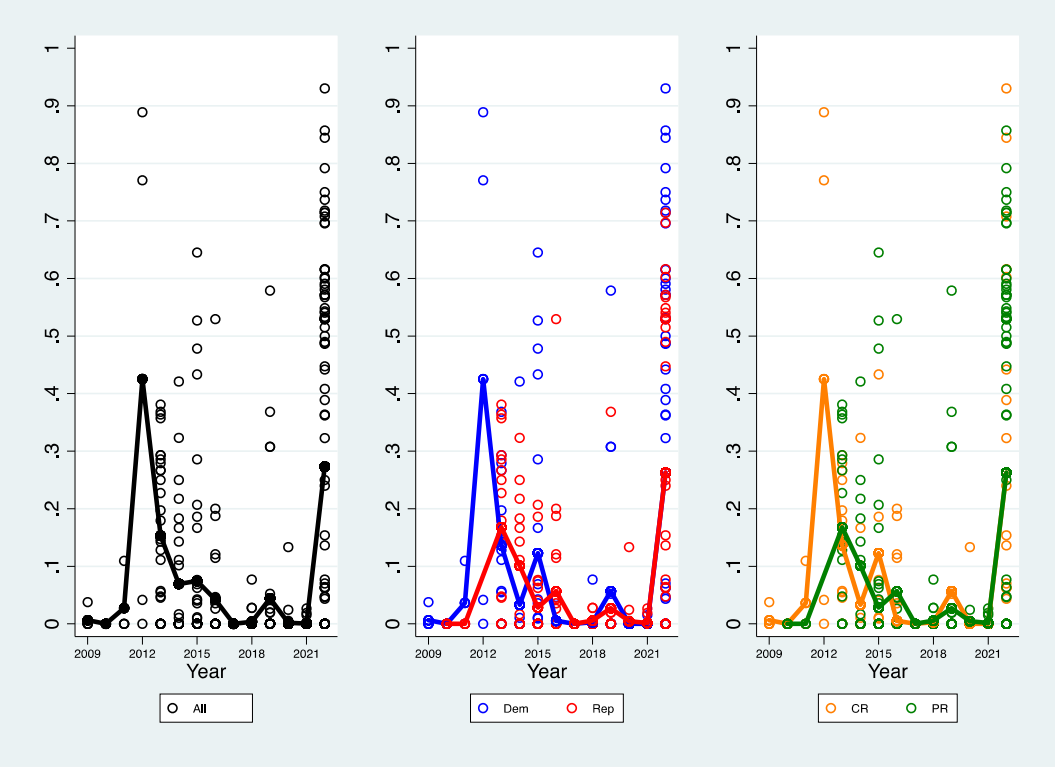
In 2022, the use of violence descriptions remerged. The proportion of statements containing any violence description increased from 2.8% of statements in 2021 to 57.3% in 2022 (p<0.01). Like the increase between 2011-2013 and the decline between 2013-2021, the increase persisted regardless of stratification by party and source. The prevalence of violence descriptions increased from 1.4% to 51.6% of Democratic statements (p<0.01), from 6.3% to 63.9% of Republican statements (p<0.01), from 0.0% to 58.62% of the Congressional Record (p=0.04), and from 2.9% to 56.8% (p<0.01) of press releases.

In Figure 3.2, I switch to my measure at the description level, depicting the yearly average proportion of all descriptions that were violence. Put another way, I calculate the proportion by

first dividing the number of violence descriptions by all descriptions in a statement. I then take the average of these measures for each year. This description-level measure follows a similar pattern to the proportion of all statements containing any violence description. Violence as a proportion of all descriptions increased from 2.7% in 2011 to 42.5% in 2012 and 15.30% in 2013. This increase persists in analyses limited to Democrats (2011: 3.6%; 2012: 42.5%; 2013: 13.6%), Republicans (2011: 0.0%; 2012: 0.0%; 2013: 16.8%), floor remarks (2011: 2.7%; 2012: 42.5%; 2013: 12.5%), and press releases (2011: 0.0%; 2012: 0.0%; 2013: 17.2%).

Between 2013 and 2021, there was a decline in the percentage of descriptions related to violence from 15.30% to 0.6% of all descriptions in 2021 ($p<0.01$). The reduction existed in statements belonging to Democratic (2013: 13.6%; 2021: 0.00%; $p<0.01$) and Republican legislators (2013: 16.8%; 2021: 0.0%; $p<0.01$), as well as floor remarks (2013: 12.5%; 2022: 0.0%; $p=0.06$) and press releases (2013: 17.2%; 2021: 0.0%; $p<0.01$).

Figure 3.2: Proportion of Descriptions That Were Violence



Note: A dot is the proportion of descriptions within a statement that are violence. The line indicates the average proportion across all statements within a year. CR = congrssional record; PR = press releases.

A surge in violence rhetoric followed this period where violence made up a small proportion of all descriptions. While less than 1.0% of descriptions in 2021 were violence, this percentage climbed to 27.3% in 2022 ($p<0.01$). The sharp increase existed in statements released by Democratic (2021: 0.0%; 2022: 26.3%; $p<0.01$) and Republican lawmakers (2021: 0.0; 2022: 26.3%; $p<0.01$). The change in prevalence persisted after limiting the analysis to press releases (2021: 0.6%; 2022: 29.6%; $p<0.01$). While the proportion of descriptions containing violence also increased in statements from the Congressional Record, growing from 0.0% in 2021 to 21.4%, the increase was insignificant ($p=0.15$).

In summary, violence descriptions followed four distinct patterns depending on the period. Between 2009 – 2011, when there were very few political statements related to

community mental health (see Table 3.1), violence descriptions comprised a very small proportion of all statements and descriptions. This period was followed by a substantial increase, lasting from 2012 to 2013. In 2013, 71.8% of all statements contained any violence description, and violence made up 15.3% of all descriptions. After this period of high violence rhetoric use, there was a significant decline in the proportion of statements and descriptions that contain violence characterizations. This reduction persisted through 2021. In 2022, violence descriptions reemerged in discussions of community mental health. Over 50.0% of all statements had any violence description, and 25.0% of all descriptions were violence. These patterns persisted after stratifying the data by party and source. In the following section, I demonstrate that the Newtown and Uvalde, but not Parkland, shootings explain these trends in violence rhetoric.

3.3.3 Focusing Events and Violence Policy Proposal Rhetoric

This section arrives at the primary purpose of this chapter: to assess whether politicians adapted their rhetoric of community mental health policy proposals following mass shootings in Newtown, Connecticut on December 14, 2012, Parkland, Florida on February 18, 2018, and Uvalde, Texas on May 24, 2022. Previously, I argued that this rhetorical modification was one of two adaptations involved in the coupling process after a focusing event: the process whereby political actors adapt policy proposals to align with the problem and political environment after a focusing event. This section examines whether the evolution of violence rhetoric described in the previous section correlates with the mass shootings in Newtown, Parkland, and Uvalde.

I find evidence that the lawmakers substantially increased their use of violence rhetoric after the mass shootings in Newtown and Uvalde. In Figures 3.3 and 3.4, I present the number of violence descriptions in statements, and the proportion of all descriptions that were violence in

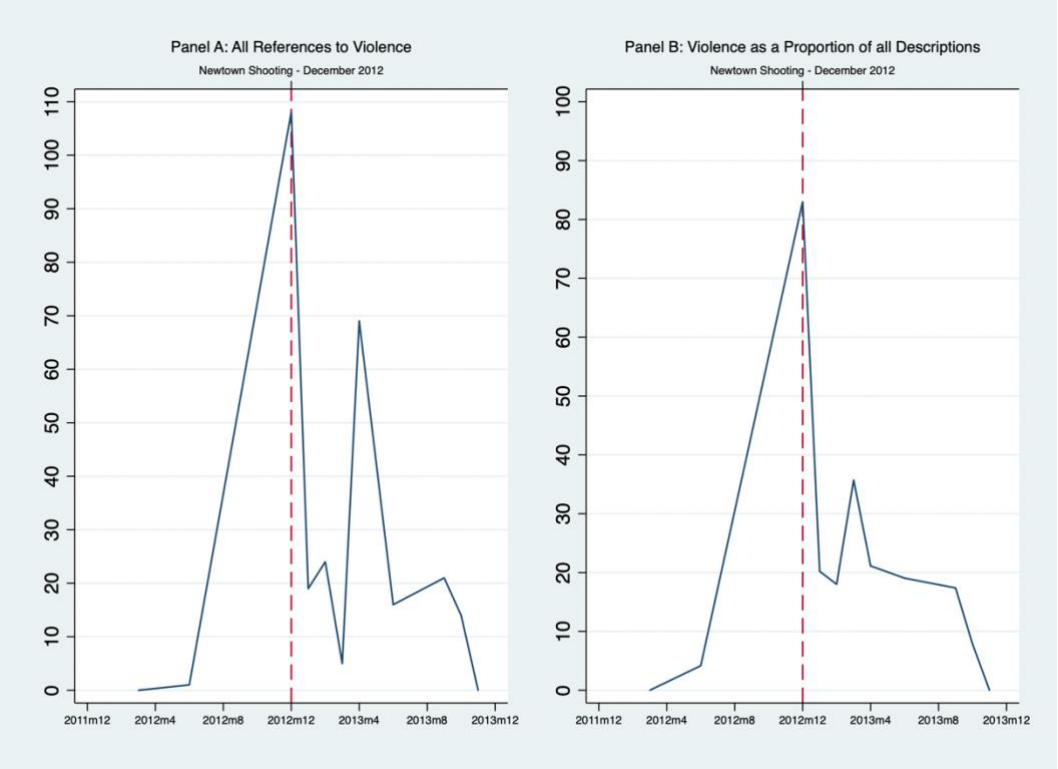
the year before and the year after each mass shooting.[32] The figures demonstrate that both focusing events dramatically increased the use of violence rhetoric. The average proportion of descriptions that were violence grew from 0.0% in the month preceding Newtown to 83.0% of all descriptions in the month when the shooting occurred. While the percentage declined to 20.2% in January 2013, 18.0% in February 2013, 35.7% in March 2013, and 21.1% in April 2013, the increase still represents a substantial departure from the period before the mass shooting.[33]

Applying the findings illustrated in Figure 3.3 to the conclusions from the previous section, the Newtown shooting likely produced the shift in violence descriptions from low use between 2009 and 2011 to high use between 2012 and 2013. The data demonstrates that lawmakers adapted their rhetoric regarding community mental health policy proposals after Newtown. When lawmakers discussed community mental health policy proposals before Newtown, violence made a small proportion of rhetoric. In contrast, after the shooting, the monthly average proportion of all descriptions that were violence was a minimum of 18.0% and a maximum of over 80.0%.

[32] The reader may note that the use of the description level measure instead of the statement level. I made this choice because the description level measure is better at capturing the amount of rhetoric that uses violence descriptions. On the other hand, the statement level measure solely illustrates whether there is any violence description. It does not provide information on whether it is the primary or a secondary means of describing community mental health policy proposals.

[33] I do not provide significance tests because I cannot run a t-test for months where there is no variation in the means. In the months preceding the Newtown tragedy, there were either zero statements that used violence rhetoric or one statement that used violence rhetoric. Consequently, I cannot calculate the average mean across multiple observations in the pre-Newtown period.

Figure 3.3: Violence Descriptions Before and After Newtown

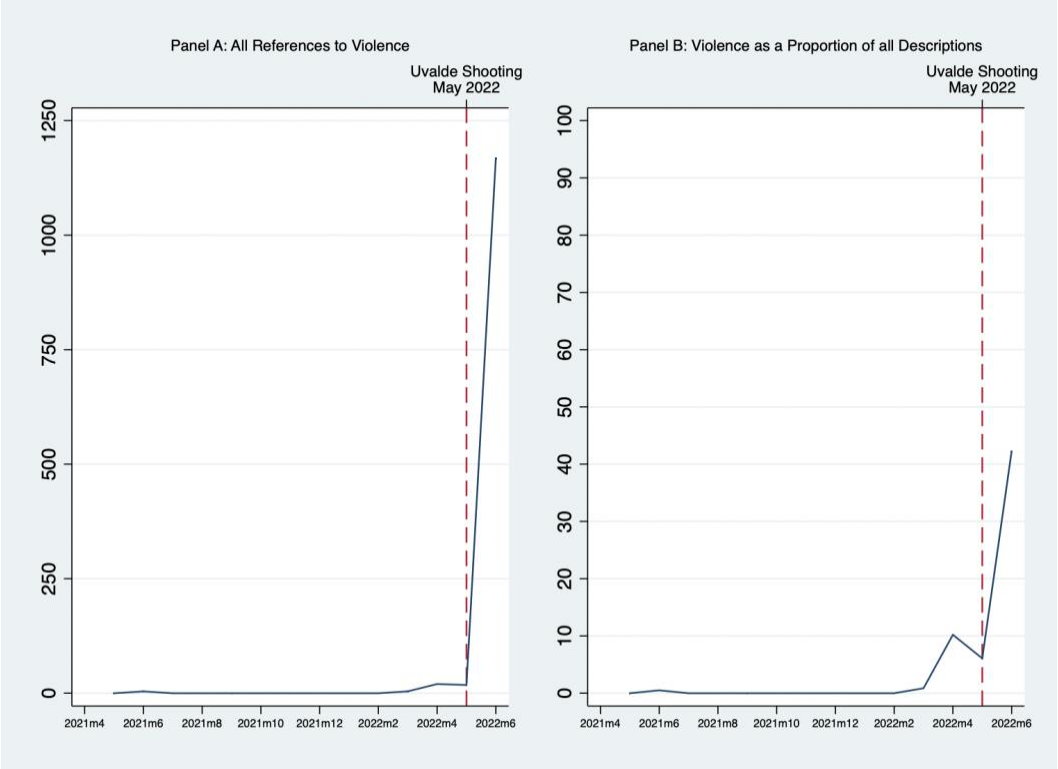


Like Newtown, I find support that politicians increased their use of violence rhetoric after the Uvalde mass shooting on May 24, 2022. Indeed, the shooting produced the increase in violence rhetoric between 2014 and 2021 and 2022 observed in Figures 3.1 and 3.2. Figure 3.4 displays that lawmakers dramatically increased their use of violence rhetoric in the month after Uvalde.[34] In the year before the shooting, the average proportion of descriptions that were violence was 1.22%. The proportion increased to 42.23% in the month after Uvalde ($p<0.01$).[35]

[34] I limited my search to statements published before July 1, 2022, so I only have data for the first month after Newtown.

[35] Another mass shooting in Buffalo, NY occurred 10 days before the shooting in Uvalde. In Appendix F, I attempt to parse out whether the Buffalo shooting on May 14, 2022 or the Uvalde shooting on May 24, 2022 produced this change in the violence rhetoric used by lawmakers. While the increase began on June 3, 2022, 20 days after the Buffalo mass shooting and 10 days after Uvalde, the data does not allow me to determine whether one incident is more or less responsible for the increase, or whether the events worked together in a self-reinforcing process by which Buffalo amplified the consequences of Uvalde. In the theory of punctuated equilibrium (Baumgartner and Jones 1993), this self-reinforcing process explains periods of "disequlibrium" where radical policy change occurs between periods of policymaking statis. Put another way, different ways of spotlighting a problem, such as indicators, feedback, and focusing events (Kingdon 1984), work together to deliver problem attention to a particular issue (Sabatier et al. 2007). For instance, Baumgartner, De Boef, and Boydstun (2008) discover that a self-

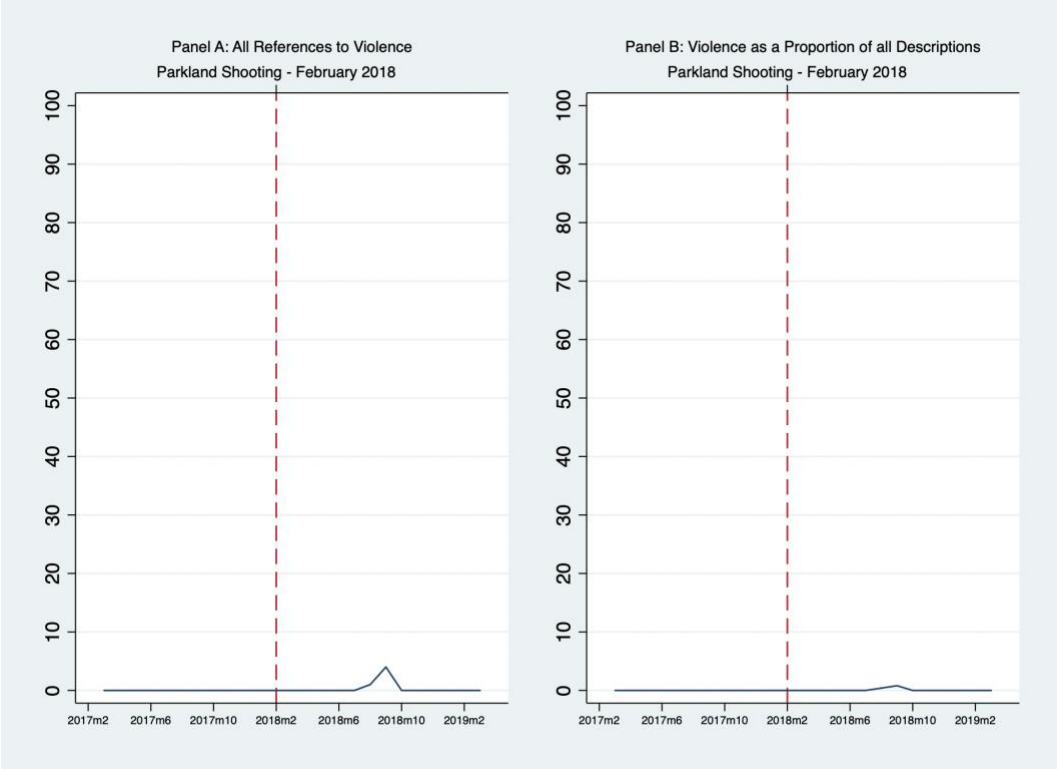
Figure 3.4: Violence Descriptions Before and After Uvalde



I do not find evidence that politicians increased their use of violence descriptions of community mental health policy proposals following the Parkland shooting on February 14, 2018 (see Figure 3.5). Indeed, there is no change in the proportion of descriptions that were violence following this focusing event, explaining the low prevalence of violence descriptions between 2014 and 2021. In the three months before and after Parkland, the proportion of descriptions that contain any violence description is 0.0%. Figure 3.5 demonstrates that the mass shooting in Parkland did not increase the use of violence rhetoric in descriptions of community mental health policy proposals.

reinforcing process, involving a "social cascade" of academic research, legal aid advocacy, state policies, and judicial rulings, propelled a shift in framing, public support, and public policy related to the death penalty. Regardless of whether Buffalo or Uvalde independently or collectively caused the increase in violence frames, the graphs demonstrate that politicians adapted their rhetoric after the May 2022 mass shootings by substantially increasing violence descriptions of community mental health policy proposals.

Figure 3.5: Violence Descriptions Before and After Parkland



3.4 Conclusion

The objective of this dissertation is to explain why political actors coupled community mental health policy proposals after school mass shootings in Newtown, Connecticut and Uvalde, Texas with the problem capturing attention after each event, while another school mass shooting in Parkland, Florida did not affect the adaptation of a similar proposal. While I answer this causal question in forthcoming chapters, the goal of this chapter was to defend that coupling occurred after Newtown and Uvalde but not Parkland. Previously, I argued that the coupling process triggered by a focusing event involves two mechanisms related to proposal adaptation and design. Indeed, focusing events motivate politicians to adapt proposal rhetoric to align with the problem garnering attention after the event, and policy entrepreneurs to modify proposal design to accommodate new political interest in the problem. Here, I answered whether

politicians adapted their rhetoric describing community mental health policy proposals to reflect the heightened interest in the perceived relationship between mental illness and violence after each mass shooting. Specifically, at the time of each event, lawmakers had recently introduced substantial community mental health policy proposals – the Excellence in Mental Health Act and the Excellence in Mental Health Addiction Treatment Expansion Act – that created or expanded a program to financially support a new community mental health provider. This chapter answered whether the incentive to adapt rhetoric to align with the problem garnering attention after each mass shooting led politicians to change how they described these community mental health policy proposals.

Despite Newtown, Parkland, and Uvalde sharing this motivation, lawmakers differed in their violence rhetoric after each event. Immediately following Newtown and Uvalde, lawmakers dramatically increased their use of violence descriptions of community mental health policy proposals. However, I do not identify any evidence that the shooting in Parkland impacted the use of violence descriptions of these proposals. This difference suggests that politicians engaged in the first mechanisms involved in the coupling process – rhetorical adaptations of community mental health policy proposals to align with the problem prioritized by the mass shooting – after Newtown and Uvalde, but not Parkland. However, I can strengthen my argument by showing how these rhetorical adjustments, specifically the increased use of violence descriptions, align a community mental health policy proposal with the problem of mental illness allegedly causing violence. The next chapter provides this analysis using the case of the Newtown shooting and the Excellence in Mental Health Act.

Chapter 4 The Excellence in Mental Health Act Rhetoric Before and After Newtown

The previous chapter established that politicians adapted their rhetoric describing community mental health policy proposals to align with the problem of mental illness allegedly causing violence after the Newtown and Uvalde mass shootings but not after Parkland. At the time of each mass shooting, lawmakers had recently introduced transformational community mental health policy proposals. Lawmakers introduced the Excellence in Mental Health Act six months before the Sandy Hook Elementary School shooting on December 14, 2012. The bill created a new type of community mental health provider, certified community behavioral health centers (CCBHCs), and a program to financially support the establishment and maintenance of the CCBHC program. Four months before Parkland on February 14, 2018 and two months before Uvalde on May 24, 2022, legislators introduced the Excellence in Mental Health and Addiction Treatment Expansion Act, which expanded the CCBHC program to more states and extended the program's duration. After the mass shootings in Newtown and Uvalde, lawmakers substantially increased their use of violence descriptions of these community mental health proposals, aligning their rhetoric with the problem at the focus of public attention after each shooting: mental illness allegedly causing violence. But how did these rhetorical adaptations align the community mental health policy proposal with the perceived relationship between mental illness and violence? This chapter answers this question using the case of the Excellence in Mental Health Act and the Newtown shooting.

The Excellence in Mental Health Act represented the most substantial reforms to federal community mental health policy in thirty years - only matched by reforms in the 1960s that created the original community mental health center program. But the passage of the bill in 2014 was a long time coming. Before adopting the bill, lawmakers introduced 15 versions of the Excellence in Mental Health Act – seven before Newtown and eight after Newtown – in three Congresses (see Table 4.1). This chapter aims to qualitatively and quantitatively demonstrate how adapting the rhetoric used to describe the Excellence in Mental Health Act attached the proposal as the solution to the problem of the perceived relationship between mental illness and violence, contributing significantly to the bill's passage.

Table 4.1: Excellence in Mental Health Act Introduction and Last Action Date

Bill Number	Date of Introduction	Date of Last Action
Before Newtown shooting		
H.R. 3200	7/14/09	10/14/09
H.R. 5636	6/29/10	6/29/10
S.4038	12/16/10	12/16/10
H.R.2954	9/15/11	11/18/11
S.2257	3/29/12	3/29/12
S.2474	4/26/12	4/26/12
H.R.5989	6/21/12	6/22/12
After Newtown shooting		
S.264	2/7/13	2/7/13
H.R.1263	3/19/13	3/22/13
H.R.3717	12/12/13	4/3/14
S.1871	12/19/13	1/16/14
S.2110	3/11/14	3/12/14
S.2122	3/12/14	3/13/14
S.2157	3/25/14	3/26/14
H.R. 4032 (P.L. 113-93)	3/26/14	4/1/14

This chapter precedes as follows: first, I will provide a brief overview of the history of federal community mental health policy. The goal of this section is to demonstrate that the 2014 Excellence in Mental Health Act represented the first substantial expansion of community mental health policy in thirty years. I then describe political rhetoric related to community mental health

policy before Newtown in years when legislators introduced the Excellence in Mental Health Act (July 2009 – November 2012). The section demonstrates that politicians primarily described community mental health policy proposals using sub-populations and disorders within the larger category of mental illness. I then turn to the effect of Newtown on this rhetoric. The findings demonstrate that, after Newtown, politicians increased their use of violence descriptions of the Excellence in Mental Health Act to portray the proposal as essential to preventing another school mass shooting.

4.1 The History of Federal Community Mental Health Policy, 1963 – 2014

The federal government has a long history in community mental health policymaking. In 1963, Congress designed and adopted a program to support the establishment of a national system of community mental health centers: entities that provide several categories of mandated mental health services regardless of a person's ability to pay. This program funded nearly 800 facilities, covering over 50.0% of the US population, or 115 million people, by 1980 (Foley and Sharfstein 1983). In 1981, the community health center program fell victim to the Reagan block grants. While few centers closed or merged because of this policy change, the block grant reduced the federal financial contribution to community mental health centers and devolved most regulatory oversight to states. After 1981, federal community mental health policy remained paralyzed as a block grant for nearly three decades until the 2014 Excellence in Mental Health Act. This chapter provides an overview of this historical context leading up to the 2014 law.

On the eve of World War II, the mental health care system appeared relatively stable. The public mental hospital with foundations originating in the early nineteenth century was at its center. These institutions provided care and treatment to individuals regardless of their ability to pay. By 1940, the resident population had reached 410,000, following a growth from 150,000 in

1903 (G. Grob 1991; Morrissey and Goldman 1986). Almost 88 percent of all mental health care episodes occurred in these institutions, with the remainder in general hospital psychiatric units (G. N. Grob and Goldman 2006). A substantial portion of state budgets supported the system of public mental hospitals, totaling $144 million. More than two-thirds of members of the American Psychiatric Association practiced in public mental hospitals (G. Grob 1991).

Over two decades, a confluence of factors ruptured the consensus that mental hospitals should remain the cornerstone of mental health treatment. Psychiatric leaders and their allies designed policies and programs to provide care and treatment in the community rather than in institutions. Several factors contributed to this transition. First, World War II revealed the extent of mental illness among the U.S. population; approximately 12 percent of all men screened for induction into the military were rejected due to neuropsychiatric concerns, accounting for nearly 40 percent of all rejects. Second, studies and exposes of state mental institutions spotlighted their decrepit conditions.[36] Third, emerging psychosocial and biological therapies offered alternatives to the tradition of institutional care. Military psychiatrists experimented with community and outpatient alternatives to institutional treatments, including early intensive treatments for persons experiencing psychosis: a population frequently treated in custodial facilities. New tranquilizing drugs, notably the synthesis of chlorpromazine in 1951 and its administration to individuals with severe mental disorders by 1952, reduced the necessity of institutions by eliminating much of the need for restraints and making patients more amenable to therapy. Fourth, groundbreaking work in psychiatric epidemiology also revealed the association between socioeconomic factors and mental illness, including that a disproportionate number of persons with emotional problems

[36] These include the 1946 publications of articles in *Life* and *Reader's Digest* – two of the magazines with the widest circulation – and book-length journalistic exposes (e.g., *The Shame of the States* in 1948 and *The Pane of Glass* in 1956) and memoirs by former patients, including Mary Jane Ward's *The Snake Pit* (1946).

were in poverty. Finally, an enhanced federal social welfare responsibility diminished the role of state governments as the exclusive funders of mental health treatment (G. Grob 1991; G. N. Grob and Goldman 2006).

During this period, congressional and administrative leadership debated national plans to develop a comprehensive community mental health center program to decrease or eliminate the reliance on state mental hospitals. These efforts involved several commission reports that differed on the extent of replacing state mental hospitals with community mental health centers. For instance, the 1961 Joint Commission on Mental Illness's final report signaled an interest in developing a structure where community mental health co-existed with a curtailed system of state mental institutions (Joint Commission on Mental Illness and Health 1961). President Kennedy's Interagency Task Force on Mental Health, guided by the recently established National Institute on Mental Health (NIMH), wanted "the mental hospital as it is now known to disappear from the scene within the next twenty-five years" (G. N. Grob and Goldman 2006, 33).

Ultimately, the NIMH's vision prevailed. On October 31, 1963, Congress enacted the Community Mental Health Systems Act. The goal of the national program was to "reduce the number of patients in custodial care by 50% or more" within one to two decades by creating 2,000 community mental health centers by 1980 (G. N. Grob and Goldman 2006; J. F. Kennedy 1963).[37] The law authorized $150 million in appropriations over a three year period for formula grants to states to support the construction of community mental health centers. Centers were required to offer "… those essential elements of comprehensive mental health services for mentally ill persons…" (S.1576 1963). The 1964 implementing regulations defined these

[37] The national program for mental health contained two other features. First, President Kennedy recommended improved care in state mental institutions through demonstration and pilot projects while the community mental health center program was in development. Second, the message articulated new funds to support the training of personnel needed to address mental health workforce shortages (J. F. Kennedy 1963).

comprehensive mental health services to include five categories: (1) inpatient services; (2) outpatient services; (3) partial hospitalization services, including day care services; (4) emergency services provided 24 hours per day within at least one of the first three services listed; and (5) consultation and education services available to community agencies and professional personnel.[38]

The program never fulfilled its intent of creating 2,000 centers by 1980. While the program funded approximately 800 centers by 1980 (Foley and Sharfstein 1983, 263), it began to receive criticism as early as 1973. The Nixon administration insisted that Congress intended the original 1963 program to be a demonstration project (Foley 1975; Gesell 1973).[39] Other concerns reflected the failure of community mental health centers to meet the needs of the "deinstitutionalized" population, particularly persons with serious and persistent disorders.[40] Despite substantial programmatic adjustments in 1975,[41] several subsequent reports continued to

[38] Centers could also serve no less than 75,000 and not more than 200,000 persons and provide needed services for persons regardless of ability to pay (§54.212 1964).

[39] As the Department of Health, Education, and Welfare Secretary from 1973 and 1975, Casper Weinberger insisted the community mental health center program was never "intended to be a categorical permanent aid program, and it should not be transformed into one simply because it already exists." Differences came to a head when, in 1973, the administration impounded funds Congress had authorized for the community mental health center grant programs. Congress, mental health interest groups, and the courts rejected his argument that the act of 1963 was designed as a demonstration project. When the National Council of Community Mental Health Centers brought judicial action against the administration, Judge Gerhard Gesell of the U.S. District Court for the District of Columbia ordered the administration to release the impounded funds. In his August 1973 ruling, he wrote that the act of 1963, "was never viewed by Congress as a demonstration program… but rather a national effort to regress the present wholly inadequate measures being taken to meet increasing mental health treatment needs" (Foley 1975; Gesell 1973).

[40] Researchers agree that the national community mental health centers program played a minimal role in deinstitutionalization. I will briefly discuss some of the factors that contributed to deinstitutionalization. To begin, states transferred patients, primarily persons with dementia, to long-term nursing facilities because the newly enacted Medicare and Medicaid programs provided an incentive to treat patients in these facilities. Indeed, while states were responsible for care costs in state mental health hospitals, the federal government assumed part or all the costs in nursing homes. In addition, the baby boom generation led to a larger population with severe and persistent mental health disorders. Community mental health centers did not offer the integrated, specialized, and long-term services that many of these individuals needed, contributing to high rates of persons with serious mental illness becoming unhoused and institutionalized in jails and prisons. Finally, states enacted policies that explicitly aimed to reduce the population in state mental health hospitalizations by creating barriers to new admissions (G. N. Grob 2016).

[41] Recognizing the need to improve the care and treatment of persons with serious mental illness in community settings, Congress, NIMH leadership, and other mental health constituents collaborated to enact the Community

criticize the mental health system as being disorganized and uncoordinated in the care and treatment of the deinstitutionalized population. President Carter and the President's Commission on Mental Health attempted to address these concerns with the Mental Health Systems Act passed on October 7, 1980. The law maintained much of the structure of the community mental health centers program, including the same comprehensive service mandates and requirement that centers serve anyone regardless of their ability to pay, though shifted the grant focus from strengthening community mental health infrastructure to targeting specific populations (G. N. Grob 2016).

Nonetheless, the 1980 Mental Health Systems Act was nearly dead upon arrival. The community mental health center program was 1 of 77 programs converted into block grants in the Reagan administration's Omnibus Budget Reconciliation Act of 1981 (Conlan 1984; H.R.3982 1981).[42,43] Under a block grant, federal agencies distribute funds to states on a formula basis. This Act reduced the total number of federal programs by approximately 25 percent. To Reagan, "this legislation did not just cut spending, it fundamentally changed social programs" (Nathan 1982).[44]

Mental Health Centers Amendments of 1975 (S. 66 1975). The amendments expanded the service categories needed to fulfill the comprehensive service requirement by adding seven services to the original five. Further, the reform provided greater specificity to the consultation and education service requirement and required community mental health centers to coordinate their care with health and social service agencies, including state mental facilities. The 1975 reforms also modified the grants supporting the community mental health center model.

[42] The law also terminated 62 programs (Conlan 1984).

[43] The 1981 Act also resulted in the repeal of the Mental Health System Act and the remaining provisions of the Community Mental Health Centers Act through the Omnibus Budget Reconciliation Act of 1981 (H.R.3982 1981). While the Mental Health Systems Act would eventually repeal the Community Mental Health Centers Act, it extended many of its provisions, including the grant programs discussed earlier, through fiscal year 1981.

[44] Conlan (1984) attributes the Reagan administration's success in converting these programs into block grants to three factors. First, Democrats failed to defend the merit of these programs in their current forms or create viable policy alternatives. Second, the Reagan administration institutionally benefitted from a Republican controlled Senate and an influential conservative coalition in the House. Finally, political actors relied on parliamentary tactics that substantially altered the rules of grant consolidation politics.

The law replaced the community mental health centers program with the Alcohol, Drug Abuse and Mental Health Services (ADM) Block Grant, which dramatically diminished the federal government's financial and regulatory role in delivering community mental health care. First, the shift to block grant funding resulted in an over 30% decrease in total federal financing for community mental health centers from 293 million in 1980 to 203 million in 1982 (Cutler, Bevilacqua, and McFarland 2003; Foley and Sharfstein 1983). Further, the block grant had no matching formula requirement, meaning federal allocations were not calculated based on state expenditure, and the funding levels were small proportions of state expenditures (Buck 1984). As Gramlich (1981) put it, the ADM Block grant became "a drop in the bucket" relative to total state spending on mental health services.

Second, the law imposed few requirements on the distribution of the limited block grant allocations, providing states immense flexibility in how they choose to disperse the funds. The law imposed only two limitations on the use of block grant allotments. Funds could be used (1) to support prevention, treatment, and rehabilitation programs and activities related to drug and alcohol use or (2) for grants to community mental health centers. In defining community mental health centers, Congress reduced the federal community mental health center comprehensive service requirement from 12 services in the 1980 Mental Health Systems Act to 5 – outpatient, day treatment/partial hospitalization, emergency services, screening of patients at risk of state hospitalization, and consultation and education - though maintained the requirement that centers serve, within their capacity, any individual regardless of ability to pay.[45] The dropping of the

[45] These five services differ from the 1963 criteria: (1) inpatient services; (2) outpatient services; (3) partial hospitalization services, including day care services; (4) emergency services provided 24 hours per day within at least one of the first three services listed; and (5) consultation and education services available to community agencies and professional personnel. Specifically, community mental health centers receiving funding under the block grant were required to provide screening for patients at risk of hospitalization, but not inpatient services.

seven criteria meant that centers no longer had to provide follow up care, inpatient services, special programs for children and the elderly, transitional services, and programs for alcohol and drug use (Cutler, Bevilacqua, and McFarland 2003; Estes and Wood 1984; Hadley and Culhane 1993).

While only a small number of community mental health centers closed or were involved in mergers following the block grant (Hadley and Culhane 1993), community mental health center funding shifted dramatically. At the height of the federal community mental health center movement in 1975, the average agency budget resembled the following distribution: 30.0% federal, 29.0% state, 10.0% Medicaid, 9.0% local government, 2.0% Medicare, 4.0% patient fees, and 8.0% other sources (Sharfstein and Wolfe 1978). By 1985, the community mental health center budget continued to rely on public funders but with a substantially different payor mix: 14.0% federal, 42.0% state, 8.0% Medicaid, 13.0% local government, 2.0% Medicare, 8.0% patient fees, and 13.0% other sources, including 7.0% from private payors. The payor distribution 10 years after the block grant was similar to that of 1985, except for the doubling in the percentage of revenue supported by Medicaid and a two-fold decrease in federal funds (Ray and Finley 1994). Indeed, by the 1990s, Medicare and Medicaid surpassed state categorical dollars in mental health care funding (G. N. Grob 2016). The data demonstrate that block granting made centers more financially reliant on states than the federal government (Larsen 1987; Ray and Finley 1994).

Several authors have documented the transformation of community mental health centers following the 1981 block grant (Beigel 1982; Hadley et al. 1994; Hadley and Culhane 1993; Jerrell and Larsen 1986; Larsen 1987; Okin 1984; Ray and Finley 1994). For instance, Drolen (1990) found in a survey of 69 community mental health centers from 27 states that centers had

cut back on consultation and education services and were serving fewer individuals without the ability to pay. Estes & Wood (1984) reported that many centers shifted their staffing and service needs to reflect the priorities of their states, many of which were focused on persons with serious and persistent mental illnesses. Indeed, while the diverse service offerings, care coordination needs, and grant programs of the community mental health centers program encouraged centers to treat many patient populations of varying severities, the decision of centers to remain closely aligned with public funding sources gave "way to the emergence of a community-based institution for long-term clients" (Larsen 1987, 24).

Since 1981, Congress has maintained the block grant structure of federal community mental health policy. The Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act of 1992 separated the ADM block into two programs: the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant.[46] The law also modified the state allocation formula, state plan requirements, and community mental health center service criteria by dropping the consultation and education requirement. The new criteria required community mental health centers to provide the following services: outpatient; emergency services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; and screening for patients being considered for admission to state mental health facilities (S.1306 1992). Other policies also changed the formula determining the amount of funds a state received and imposed additional requirements on the block grant.[47] Nonetheless, Congress passed no law that reinstituted the

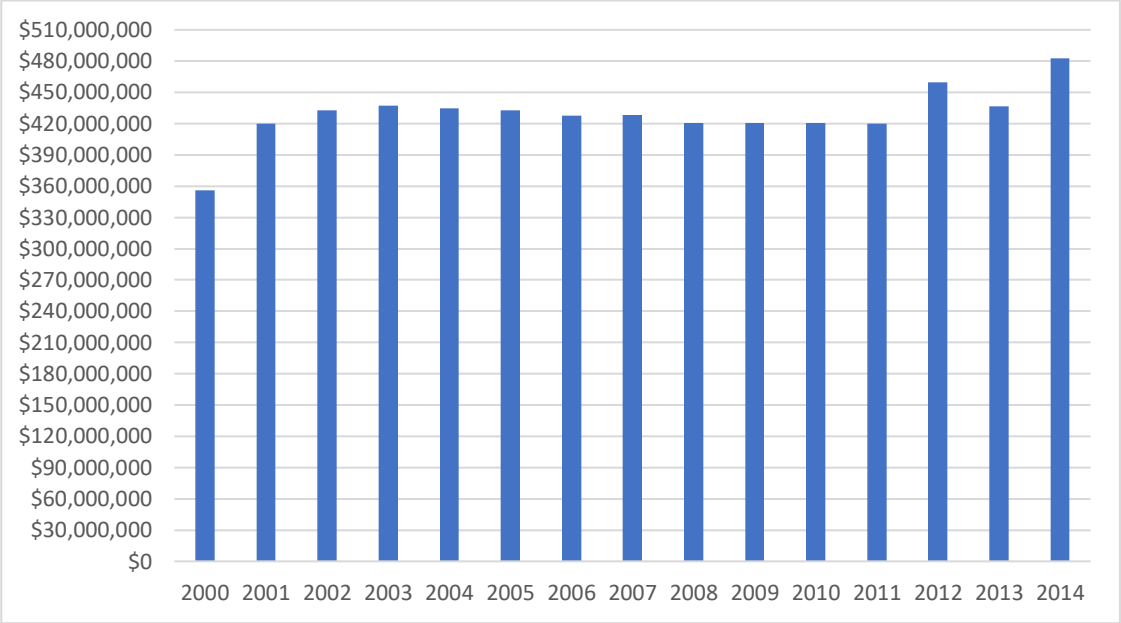
[46] In addition, the Alcohol, Drug Abuse and Mental Health Services Administration Reorganization Act of 1992 extended the community entities eligible to receive a grant under the MHBG to include, in addition to community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs.

[47] The Children's Health Act of 2000 required MHBG funding be used to serve children with a serious emotional disturbance and adults with serious mental illness (H.R.4365 2000). Besides these changes, today's MHBG largely resembles Reagan's 1981 block grant.

national community mental health center program of the 1960s and 1970s or substantially modified federal involvement in community mental health services beyond the block grant. In summary, community mental health policy remained stable for over three decades until the 2014 Excellence in Mental Health Act.

MHBG appropriations exemplify this stability (see Figure 4.1). MHBG allotments grew minimally between 1981 and 2014. In 1981, Congress appropriated $204 million to the block grant. After 11 years, the block grant funds increased to just $280 million, "a reduction of over $81 million in purchasing power when contrasted with the growth of inflation measured against the consumer price index for this same period" (Ray and Finley 1994). Since then, appropriations have increased to just $356,000,000 in 2000 to only $420,774,000 in 2010.

Figure 4.1: Annual Appropriations to Community Mental Health Services Block Grant



Source: Substance Abuse and Mental Health Services Administration. (2023). SAMHSA Budget Archive. Accessed April 29, 2023. https://www.samhsa.gov/about-us/budget/archive.

Thus, on the eve of reform, there had been minimal movement in federal community mental health policy for thirty years. Congress terminated the 1963 national community mental

health center program in 1981. Its replacement, the MHBG, persists in federal statute. Today, the MHBG continues to define community mental health centers using the 1992 requirements. Federal MHBG appropriations have increased only slightly over the past three decades. It is in this policy context that politicians increased federal involvement in community mental health care by adopting the Excellence in Mental Health Act in 2014.

The rest of this chapter examines the rhetorical component of the coupling process that contributed to the 2014 Excellence in Mental Health Act's coupling and adoption. As a reminder, coupling is the process by which political actors adapt existing policy proposals to align with the problem prioritized by and political environment after a focusing event. Focusing events incentivize coupling by providing a problem that political actors can hook to their policy proposals, carrying the proposal through the legislative process. Previously, I argued that the coupling process following a focusing event involves two mechanisms: one related to proposal rhetoric and another involving proposal design. The following sections build on Chapter 3's analysis of the impact of mass shootings on community mental health proposal rhetoric. Specifically, I expand upon Chapter 3's finding that lawmakers substantially increased their use of violence rhetoric describing community mental health policy, including the Excellence in Mental Health Act, following Newtown. In this section, I answer how this rhetorical adaptation aligned the Excellence in Mental Health Act with the problem garnering attention after Newtown, contributing to the coupling process and the bill's legislative enactment.

I begin by describing how lawmakers discussed the Excellence in Mental Health Act before Sandy Hook. Between January 1, 2009 and the Newtown shooting on December 14, 2012, lawmakers introduced the Excellence in Mental Health Act seven times. During this period, politicians primarily described the Excellence in Mental Health Act and other minor community

mental health policy reforms using sub-populations and disorders within the larger category of mental illness. I then turn to the effect of Newtown on this rhetoric. After Newtown, legislators introduced the Excellence in Mental Health Act eight times before the bill's enactment in March 2014. The results demonstrate that the descriptions of the Excellence in Mental Health Act introduced following Newtown substantially differed from the rhetoric of before. Specifically, lawmakers newly used violence rhetoric that described the bill as essential to preventing another school mass shooting.

4.2 Excellence in Mental Health Act Rhetoric Before Newtown

Before the shooting at Sandy Hook Elementary School in Newtown, Connecticut on December 14, 2012, lawmakers devoted minimal political attention to community mental health, and when they did, Democratic legislators were responsible. Between 2009 – the year when lawmakers introduced the first Excellence in Mental Health Act – and the Newtown shooting, legislators held 16 hearings related to mental or behavioral health, 10 of which referenced community mental or behavioral health.[48] Committees related to the military, veterans, or homeland security held all but one of the 16 hearings. Further, lawmakers made only 16 floor remarks and issued two press releases related to community mental health during these three

[48] I identified hearings using the following strategy: first, I identified the committees responsible for reviewing community mental health legislation by identifying the committees where community mental health bills were referred from 2009 and 2014. Those committees included seven House committees – Energy and Commerce; Ways and Means; Education and Labor; Oversight and Government Reform; Budget; Judiciary; and Science, Space, and Technology – and four Senate committees: Veterans, Armed Services, Agriculture and Natural Resources. I then searched the titles of hearings for those relevant to mental health or behavioral health using the keywords: "mental health," "behavioral health," "psych," and "suicide." After identifying hearings related to mental or behavioral health, I used a keyword search to find hearings relevant to community mental health. Specifically, I searched the following phrases in the narrative of the hearing: "community mental," "community behavioral," "community-based mental," "community-based behavioral," "community based mental," and "community based behavioral." The results from this search provided the universe of hearings related to community mental or behavioral health between 2009-2014.

years. Democrats released all press releases and made all but two of the 16 floor remarks before Newtown.[49]

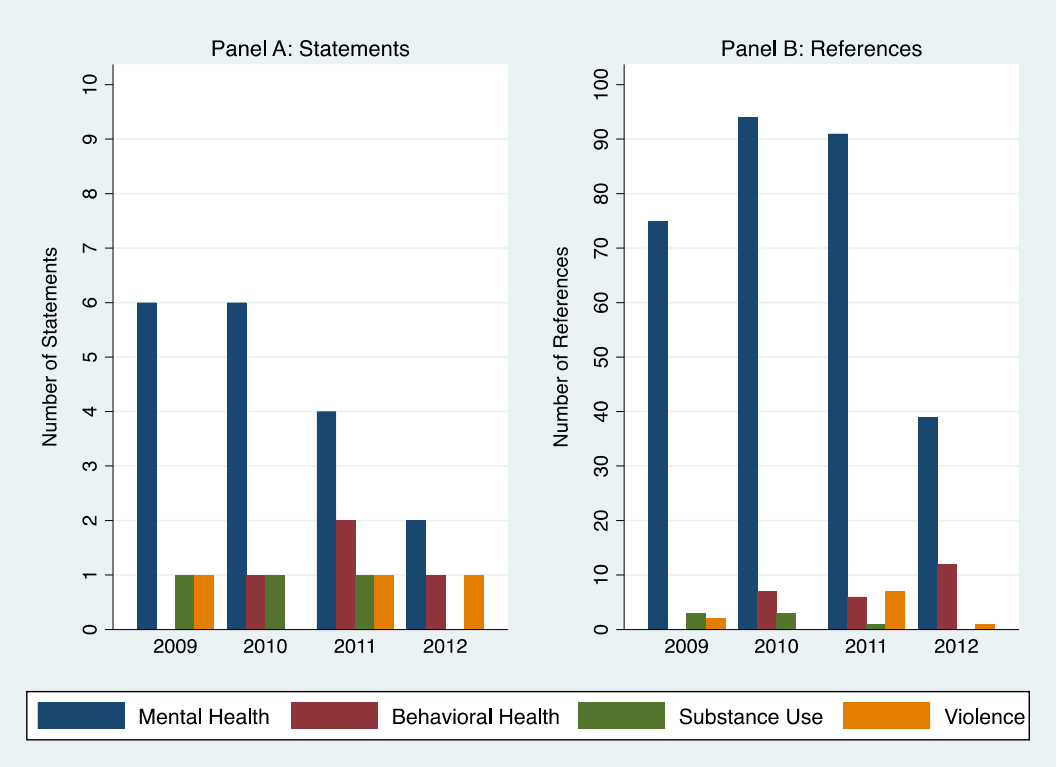
When lawmakers made a rare statement about the Excellence in Mental Health Act or other minor community mental health policy proposal, mental health was the dominant description of community mental health policy. Figure 4.2 illustrates the number of statements and descriptions related to mental health, behavioral health, substance use, and violence in press releases and floor remarks in the years before Newtown.[50] The y-axis on Panel A is the number of statements that use the four descriptions, and the y-axis on Panel B contains the total number of descriptions associated with mental health, behavioral health, substance use, and violence. The figure demonstrates that lawmakers used mental health descriptions more frequently than the other three descriptions. Indeed, 56.7% of all references were mental health descriptions in comparison to 4.7% for behavioral health, 1.3% for substance use, and 1.9% for violence.[51]

[49] Senator Collins (R-ME) made a floor remark in 2010 and another in 2011 about increasing mental health services for older Americans through community-based care settings (Introductory Statement on S. 3698; Congressional Record Vol. 156, No. 117 2010; Statements on introduced bills and joint resolutions; Congressional Record Vol. 157, No. 35 2011)

[50] Please see Appendix C for my methodological approach for identifying the topics present in political statements related to community mental and Appendix E for the codebook.

[51] The other 35.4% of references were associated with other characterizations. I typically applied this code when analyzing discussions of bills that contained many provisions, including one related to community mental health, for instance, discussions of appropriations bills that authorized federal funding for various programs. Press releases or floor remarks discussing this type of legislation include conversations about provisions unrelated to community mental health, such as childcare, economic development, and education. We would code references to these unrelated topics as other.

Figure 4.2: Four Descriptions Before Newtown (December 14, 2012)[52]



These mental health descriptions primarily focused on sub-populations and disorders within the category of mental illness.[53] For instance, Senator Reed's (D-RI) 2012 floor statement regarding infrastructure grants to support the construction and modernization of community mental health services highlighted persons with serious mental illness: "38,000 adults and 11,000 children in the state have a serious mental illness, and approximately 15 percent of Rhode Island adults report suffering from serious psychological distress every year" (Statements of Introduced Bills and Joint Resolutions; Congressional Record Vol. 158, No. 52 2012). Senator Collins (R-

[52] Please refer to the "Methodological Approach" section in Chapter 3 for a description of my methodological approach to collecting and analyzing the 18 press releases and floor remarks included in this figure.
[53] Two floor remarks discussed community mental health's target population in general terms (Statements on introduced bills and joint resolutions; Congressional Record Vol. 156, No. 167 2010). For instance, in Representative Matsui's (D-CA) remark discussing her support for making May Mental Health Month, she mentioned the 57 million people in the United States today with disorders ranging from "bipolar disorder to bulimia and other eating disorders to anxiety-related conditions like post-traumatic stress disorder…" that impact "…workers, their bosses, their employees, their mothers and fathers, sisters and brothers and close friends…" and "all racial, ethnic and socioeconomic groups" (Mental Health Month; Congressional Record Vol. 156, No. 79 2010).

ME) also mentioned community mental health as a part of the solution to "one of the most daunting public health challenges…(of increasing) access to quality mental health services for the more than 44 million Americans with severe, disabling mental disorders that can devastate their lives and the lives of the people around them" (Introductory Statement on S. 3698; Congressional Record Vol. 156, No. 117 2010). Lawmakers also discussed veterans, including when describing a bill that would provide the Veterans Administration with "flexibility to contract with community mental health centers and other qualified entities in areas not adequately served by the VA" and uninsured and underinsured individuals: "(we call for) increased funding for comprehensive community services for low income and uninsured people living with mental illnesses" (Durbin 2010; National Mental Health Awareness Month; Congressional Record Vol. 156, No. 81 2010). Other descriptions mentioned include children and dual eligibles. In summary, lawmakers described the Excellence in Mental Health Act and other minor community mental health policy reforms using a variety of groups and disorders within the general category of mental illness.

While the dominant description before the shooting in Newtown was mental health, two lawmakers used violence descriptions of community mental health proposals in three floor remarks prior to the shooting, demonstrating that the perception that mental illness causing violence was a problem preexisted the focusing event. For instance, Senator Durbin (D-IL) began a 2011 floor remark about the inability of community mental health centers to support counseling services on college campuses with the story of a mass shooting at a university:

> "Mr. President, three years ago, a mentally disturbed gunman walked into a campus lecture hall at Northern Illinois University and shot 22 students, killing 5 of them. Northern Illinois University is not the first college to experience this kind of tragedy. We all remember the horrific events at Virginia Tech in 2007 where 32 lives were taken by a

> gunman. In the aftermath of these shootings, we asked what could have been done to prevent it... For a long time, we have overlooked the mental health needs of students on college campuses" (Statements of Introduced Bills and Joint Resolutions; Congressional Record Vol. 157, No. 49 2011).

In 2012, Senator Begich's (D-AK) advocated for mental health first aid on the Senate floor, including discussing the resources available at community mental health centers. He stated that this "program may also help to avert violence incidents; Mental Health First Aid gained wide public recognition in the aftermath of the tragic shootings in Tucson, AZ, involving our former colleague Rep. Gabrielle Giffords" (Introductory Statement on S. 3325; Congressional Record Vol. 158, No. 95 2012). These statements demonstrate that some lawmakers saw value in describing the community mental health policy proposals using descriptions of violence before the Newtown shooting.

In summary, before Newtown, very few political statements referenced the Excellence in Mental Health Act or other community mental health policy proposal. But, when politicians discussed it, lawmakers primarily described community mental health policy proposals using various populations and disorders within the general category of mental illness. These descriptions were inconsistent, including serious mental illness, veterans, youth, low-income and uninsured populations, and dual eligibles. While lawmakers rarely attached community mental health to violence descriptions, the existence of this frame in a few statements demonstrates that the public and politicians already perceived that mental illness allegedly causing violence was a problem before Newtown. In the next section, I examine how politicians adapted their rhetoric of community mental health policy proposals to align with the increase in public attention to problem of the alleged link between mental illness and violence after Newtown.

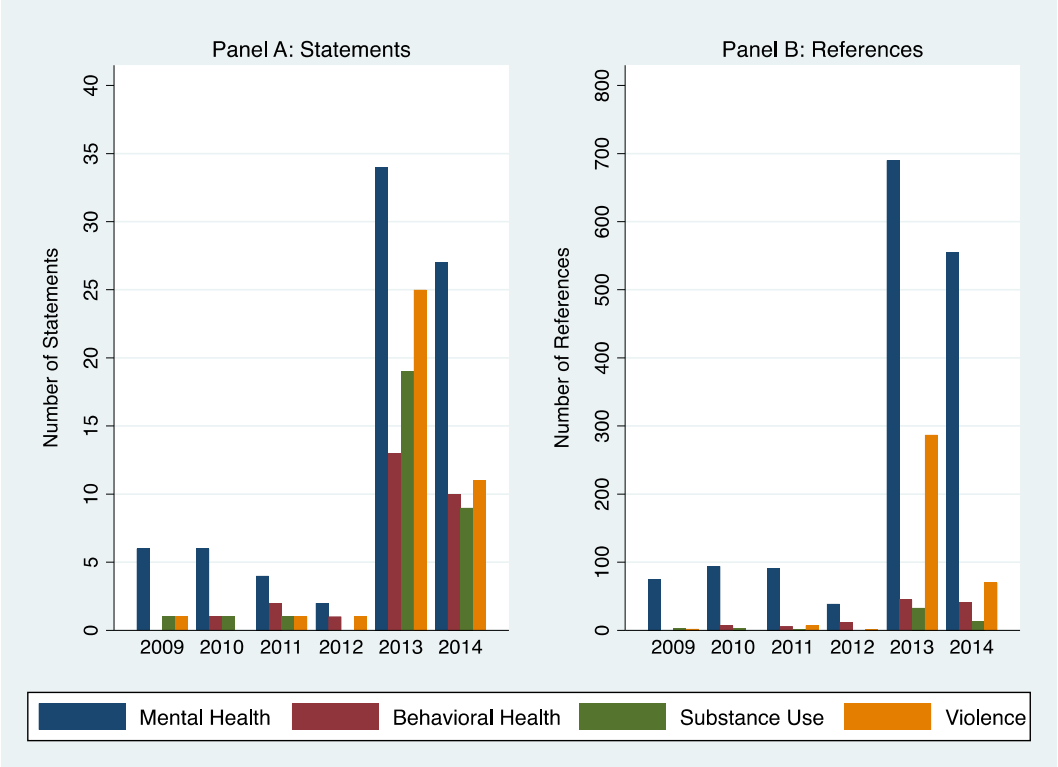
4.3 Excellence in Mental Health Act Rhetoric After Newtown

The Newtown shooting changed political rhetoric related to the Excellence in Mental Health Act. After Newtown, lawmakers not only issued more statements discussing this bill but also changed how they described the legislation. Indeed, in political statements related to community mental health policy proposals, lawmakers increased their use of violence rhetoric, including statements that explicitly attached the Excellence in Mental Health Act as part of the solution to preventing another Newtown.

Figure 4.3 adds the two years after the December 14, 2012 Newtown shooting to Figure 4.2.[54] Panel A demonstrates that lawmakers issued many more statements about community mental health after the shooting. Between January 1, 2012 and December 14, 2012, lawmakers made two floor remarks and issued zero press releases compared to 15 floor remarks and 19 press releases between December 15, 2012 and December 31, 2013. In addition to making more political statements about community mental health, Panel A demonstrates that lawmakers sharply increased the number of statements containing any violence description. Compared to the three statements with violence descriptions before Newtown, lawmakers made 39 statements referencing violence after the focusing event. Moreover, the number of violence descriptions grew from one in 2012 to 287 in 2013. The results in Figure 4.3 illustrate the sudden increase in the number of community mental health statements and violence descriptions within these statements.

[54] I exclude years after 2014 because lawmakers adopted the Excellence in Mental Health Act on April 1, 2014.

Figure 4.3: Four Descriptions Before and After Newtown (December 14, 2012)



Note: I include the two floor remarks made immediately after the Sandy Hook shooting in 2012 in the 2013 group. Lawmakers made these statements on December 18, 2012 on the House floor (Newtown; Congressional Record Vol. 158, No. 163 2012) and December 19, 2012 on the Senate floor (Department of Defense Appropriations Act -- Continued; Congressional Record Vol. 158, No. 164 2012)

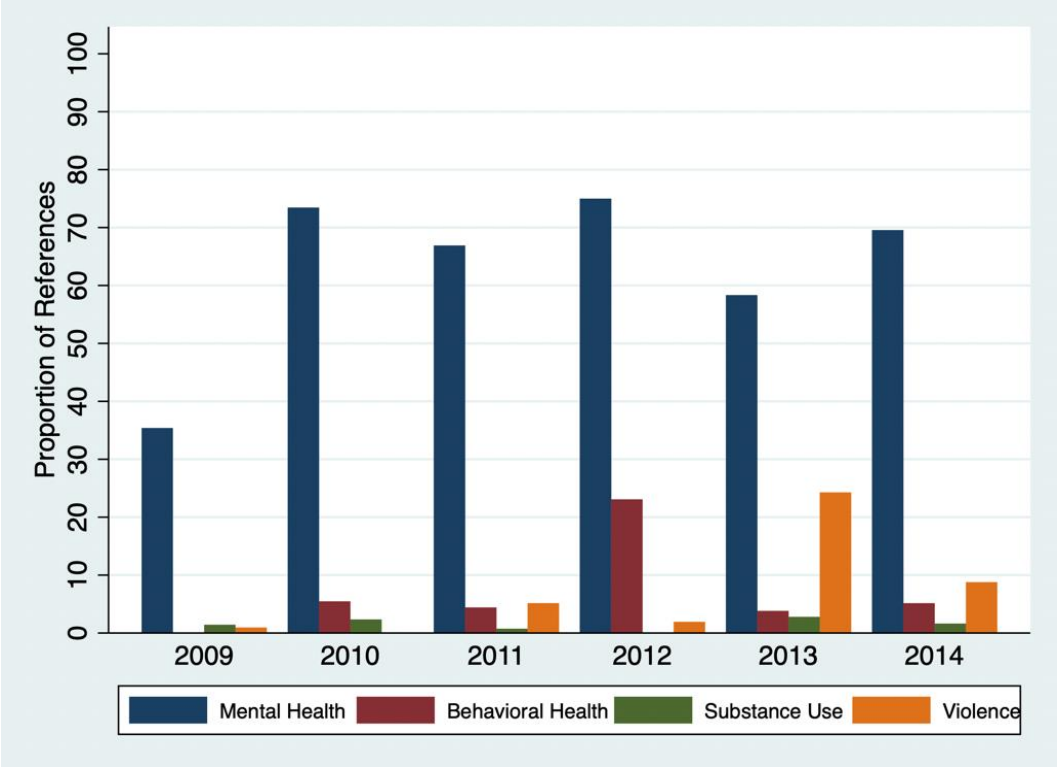
However, Figure 4.3 also demonstrates that lawmakers increased their use of other descriptions after Newtown. Indeed, legislators made many more statements related to community mental health in 2013 than in previous years, and the number of statements and descriptions containing mental health, behavioral health, substance use, and violence frames grew along with this increase. Thus, it is possible that the distribution of descriptions within statements and among references remained the same. This would occur if the number of statements and references that contained mental health, behavioral health, substance use, and violence all increased in similar amounts, so that the proportion of items with these descriptions after Newtown remained equivalent to that of before.

I do not observe this. In fact, I find that violence is the only description that comprised a significantly larger share of all references after Sandy Hook (see Figure 4.4). Indeed, the percentage of descriptions that were violence increased from 1.9% in 2012 to 24.3% in 2013 (χ^2: 13.90, $p< 0.01$), whereas the proportion of references that were mental health (2012: 75.0%; 2013: 58.3%; χ^2: 5.73, $p=0.02$) and behavioral health (2012: 23.1%; 2013: 3.8%%; χ^2: 42.03, $p<0.01$) decreased and the proportion that were substance use remained stable (2012: 0.0%; 2013: 2.8%).[55]

These violence descriptions often involved discussions of the need to improve community mental health care so that the treatment system intervenes before "someone does something that tragically impacts their lives and the lives of others" (Blunt 2013a). Put another way, "we need to identify and treat people suffering from mental illness before they damage or destroy other lives" (Bennet 2013). These statements demonstrate that the goal of the Excellence in Mental Health Act was to solve the problem of violence by identifying and treating persons with mental illness before they harm others.

[55] One might notice the violence percentages are different from the proportions in Figure 3.2. This is because I include the statements released after Newtown in 2012 in the 2013 data.

Figure 4.4: Four Descriptions as a Proportion of All References Before and After Newtown (December 14, 2012)



Note: I include the two floor remarks made immediately after the Sandy Hook shooting in 2012 in the 2013 group. Lawmakers made these statements on December 18, 2012 on the House floor (Newtown; Congressional Record Vol. 158, No. 163 2012) and December 19, 2012 on the Senate floor (Department of Defense Appropriations Act -- Continued; Congressional Record Vol. 158, No. 164 2012)

Commonly, legislators acknowledged that "studies show that individuals with a serious mental illness are actually more likely to be a victim of violence than a perpetrator" (Rubio 2013), but immediately followed these statements by emphasizing the threat of untreated mental illness: "however, there are too many times when lack of diagnosis and effective treatment has led to horrible tragedies" (Coons 2013), or "…in the absence of timely diagnosis, early intervention, and treatment, people experiencing illness are at risk of committing acts of violence — at a rate 15 times higher than those in treatment" (Leahy 2013). Statements from Democratic Senators Coons (DE), Leahy (VT), and Stabenow (MI) and Republican Senators Blunt (MO), Collins (ME), and Rubio (FL) contained some version of this mixed message: most persons with

mental illness are not violent, but, when they are, the consequences are horrific (Blunt 2013b, 2014; Collins 2013; Coons 2013; Leahy 2013; Rubio 2013).

Many violence descriptions explicitly linked the Excellence in Mental Health Act with the Newtown shooting. Lawmakers from both sides of the aisle emphasized that Newtown spotlighted the need to improve the mental health treatment system to prevent another tragedy:

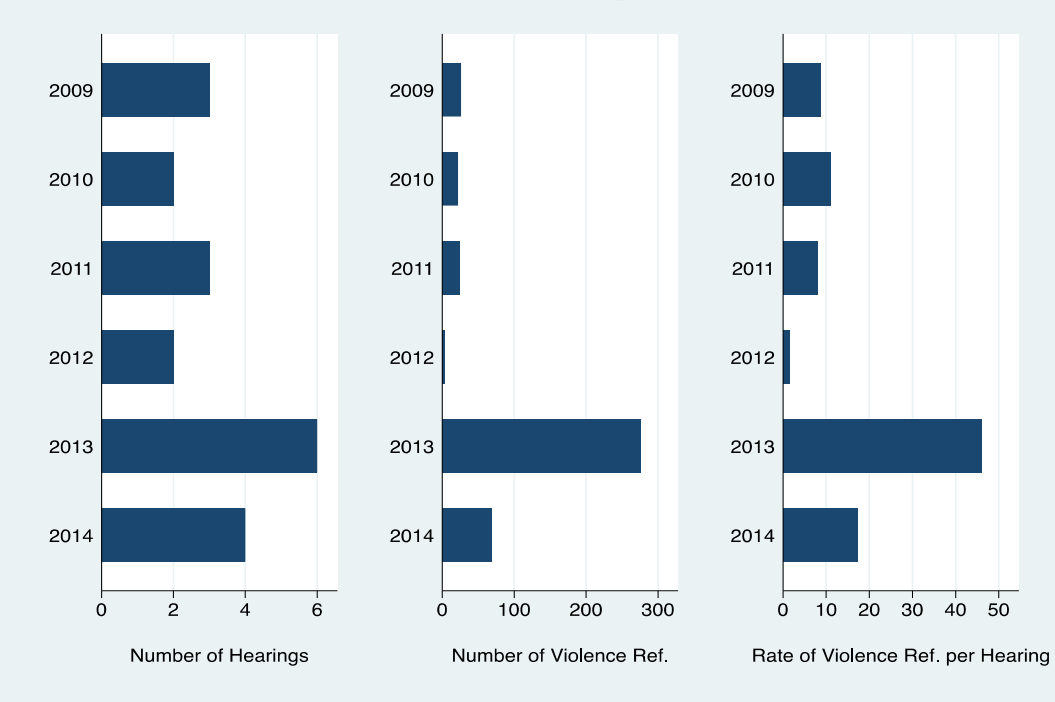
> The horrific tragedy that occurred in Newtown, Connecticut, last December filled the hearts of all Americans with sorrow. It also brought to the forefront several crucial issues we must address to better understand and prevent the multiple causes of such terrible violence. In the aftermath of the shootings in Newtown, it is clear that we need to take a serious look at our mental health system to determine how we can better support and care for individuals and families afflicted by serious mental illness (Collins 2013).

As Reed (2013) stated, "in the wake of tragedies like Sandy Hook, we must work together to spend federal dollars more wisely when treating people who are mentally ill. This bill will help address our fragmented mental health system and ensure that more patients have access to the care they need by offering current community mental health centers a chance to expand their services…" Others called for mental health treatment as a top priority in a comprehensive, commonsense approach to making our communities safer in the wake of tragedies like the shooting at Sandy Hook Elementary School (Blumenthal 2013).

Up to now, I have exclusively presented qualitative and quantitative data derived from press releases and floor remarks. I have shown that lawmakers issued more statements about the Excellence in Mental Health and other minor community mental health policy proposals after Newtown, and the prevalence of violence descriptions within these statements also increased. I find that these trends persist in data on congressional hearings. In Figure 4.5, I display the number of hearings related to community mental health that referenced violence. The results

confirm the findings in Figures 4.3 and 4.4. The number of hearings related to community mental health and the number of violence descriptions within these hearings surged following the shooting in Newtown. Indeed, I find that the rate of violence descriptions per hearing increased abruptly after December 14, 2012 from 1.5 per hearing in 2012 to 46 per hearing in 2013. In sum, the shooting in Newtown stimulated lawmakers to rapidly hold more hearings related to community mental health and use more violence descriptions in those hearings.

Figure 4.5: Hearings Related to Community Mental Health and Violence Descriptions Within Hearings



4.4 Conclusion

This dissertation aims to explain why Newtown and Uvalde catalyzed the coupling of the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Act with the problem of mental illness allegedly causing violence, while a similar shooting in Parkland did not. Before answering this question, I must demonstrate that political actors pursued coupling after Newtown and Uvalde but not Parkland. Coupling is the process by which

political actors adapt existing proposals to align with the problem prioritized after a focusing event in a politically feasible way. Chapters 3 and 4 focused on one of the two adaptations involved in coupling after a mass shooting. Each mass shooting incentivized politicians to adapt policy proposal rhetoric in response to increased public attention to the problem of mental illness allegedly causing violence, so the proposal became the perceived solution to the problem. Despite similar settings, problems, community mental health policy proposals, and bipartisan support for the policy from party members, Chapter 3 demonstrated that politicians increased their use of violence descriptions of community mental health policy proposals following the mass shootings in Newtown and Uvalde but not Parkland. This chapter built on Chapter 3 by examining how these violence descriptions aligned the Excellence in Mental Health Act with the problem prioritized after Newtown. Before Newtown, lawmakers described the Excellence in Mental Health Act and other community mental health policy using a variety of specific populations and disorders within the general category of mental illness. After Newtown, political rhetoric related to the Excellence in Mental Health Act transformed by increasing their use of violence descriptions of the bill, including statements suggesting that the legislation would help prevent another Newtown.

But what about the other element of the coupling process? Focusing events also incentivize policy entrepreneurs to adapt policy proposal design in response to an event increasing political attention to a problem. Specifically, these events motivate policy entrepreneurs to modify proposal design to accommodate the new politicians, and their partisan and ideological preferences, interested in the issue following the focusing event. In the upcoming chapter, I examine whether policy entrepreneurs adapted the design of the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act following

Newtown and Uvalde increasing political attention to the problem of mental illness allegedly causing violence.

Chapter 5 Pursuing Coupling After Newtown and Uvalde

The Newtown, Parkland, and Uvalde mass shootings are examples of events that demanded universal attention. Each focusing event involved a school mass shooting where a former pupil killed students and teachers. Newtown resulted in the deaths of 26 people. The Parkland shooter murdered 17 individuals. And the Uvalde shooter killed 21. These events not only focused public and political attention on gun control but catalyzed and surged interest in the problem of mental illness allegedly causing violence, incentivizing political actors to hook existing community mental health proposals to this problem in an attempt to move the bills to the top of the legislative agenda. This process is called coupling: political actors adapt proposals to align with the problems prioritized by a focusing event in a politically feasible way, increasing the likelihood that the proposals would become law.

Indeed, each shooting motivated political actors to couple substantial community mental health policies proposals introduced only months before each shooting with the problem garnering attention after the event: the perceived relationship between mental illness and violence. The Newtown shooting incentivized political actors to adapt the Excellence in Mental Health Act. The bill created a new type of community behavioral health provider, CCBHCs, and an eight state Medicaid program to financially support establishing and maintaining the CCBHC program, representing the most expansive reform to federal community mental health policy in thirty years. The Parkland and Uvalde shooting motivated these same actors to adapt the

Excellence in Mental Health and Addiction Treatment Expansion Act: a bill that would expand the CCBHC program to more states and extend the program by several years.

I have shown that politicians acted upon the incentive to engage in coupling after Newtown and Uvalde by changing how they described these policy proposals. Following these two shootings, politicians used more violence rhetoric when describing the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act, claiming the bills would address the perceived relationship between mental illness and violence. However, politicians made no such rhetorical adaptations after Parkland. Indeed, despite having much of the same problem, policy, and political infrastructure, politicians only pursued rhetorical adaptations of policies creating or expanding the CCBHC program after Newtown and Uvalde, but not Parkland.

But what about the other element of coupling? In addition to proposal adaptations, the Newtown, Parkland, and Uvalde shootings motivated policy entrepreneurs to adapt policy proposal design to accommodate new political interest in a problem prioritized after a focusing event. Policy design refers to the content of a policy proposal, including the problem addressed, the populations targeted, and the structure of rewards and sanctions (A. Schneider and Sidney 2009). Putting aside Parkland, this chapter finds that policy entrepreneurs adapted the design of the Excellence in Mental Health Act following Newtown and the Excellence in Mental Health and Addiction Treatment Expansion Act after Uvalde in response to increased political attention to the problem of mental illness allegedly causing violence. Policy entrepreneurs adapted proposal design to reflect new Republican interest in the problem garnering attention after each shooting. Specifically, they modified the design to accommodate Republican public policy preferences for limited public health programs with devolved regulatory responsibilities.

By the end of this chapter, I will have demonstrated that Newtown and Uvalde not only incentivized political actors to couple substantial community mental health policy proposals with the problem of mental illness allegedly causing violence but that these actors acted upon these incentives. Politicians adapted the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act rhetoric by increasing the use of violence descriptions, and policy entrepreneurs modified the design by changing the content of the policy to reflect Republican public policy preferences. These two adaptations substantially increased the likelihood of achieving a coupled policy that lawmakers would prioritize on the legislative agenda because it was perceived to solve the problem garnering attention after the Newtown and Uvalde shootings.

However, the Newtown and Uvalde shootings, like Parkland, solely provided incentives to engage in coupling. Nothing guaranteed that Newtown, Parkland, or Uvalde would trigger political actors to engage in the adaptation of the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act to align with the problem of mental illness allegedly causing violence. So, why did political actors engage in coupling after Newtown and Uvalde?

This chapter begins to answer this question fundamental to my dissertation. I find that support from lawmakers occupying positions with relevant agenda controls was crucial to the decision to pursue coupling after the Newtown and Uvalde shootings. Agenda setters possess powers that allow them to greatly influence which bills advance to the floor for a vote and which stagnate in committee. I predicted that the political actors responsible for coupling only pursue proposal adaptation when agenda setters support the policy proposal before the coupling process concludes. This support provides information to these politicians and policy entrepreneurs that

the costs of coupling, including time spent designing and releasing new political statements and negotiating new policy designs, are likely worth the public policy benefit of substantially increasing the likelihood that the coupled proposal moves to the top of the legislative agenda. Indeed, this support signals that lawmakers occupying relevant agenda setting positions will likely refrain from using their agenda controls to prevent the coupled policy from legislative advancement.

I find support for this expectation. After the mass shootings in Newtown and Uvalde, agenda setters provided this display of support for the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act. The chair of the Senate and House committees where community mental health policy reforms were referred publicly supported the legislation through sponsorship. Further, statements from other lawmakers explicitly thanked the committee chairs for expediting the bill through the legislative process.

This chapter achieves two aims. First, I demonstrate that policy entrepreneurs adapted the design of the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act to accommodate new political interest in the problem prioritized by each mass shooting. I then answer why political actors engaged in coupling after Newtown and Uvalde, offering evidence that support from agenda setters was essential to the decision to adapt these community mental health policy proposals to align with the problem of mental illness allegedly causing violence.

5.1 Excellence in Mental Health Act Design Before Newtown

This section describes the design of the Excellence in Mental Health Act before the Newtown mass shooting on December 14, 2012. The seven versions of the Excellence in Mental Health Act introduced before Newtown created a new nationwide, permanent community mental

health center program, representing a policy that deviated substantially from existing community mental health policy. As a reminder, since 1981, federal involvement in community mental health care was limited to a block grant where states received a set amount of funds to distribute to community mental health service providers. The first seven iterations of the Excellence in Mental Health Act proposed a new community mental health provider – federally qualified behavioral health centers (FQBHCs) – that would receive enhanced Medicaid reimbursement for providing comprehensive mental health services to any patient regardless of ability to pay.

The objective of the Excellence in Mental Health Act before Newtown was to apply the popular concept of parity to community mental health services. Parity is the idea that mental health and substance use disorders should be treated like other medical illnesses. The parity idea originates with insurance; health insurers should provide mental health and substance use disorder benefits at levels equitable to benefits for other medical conditions. Its first appearance in federal law occurred in 1961 when President Kennedy ordered the U.S. Civil Services Commission to require the health insurer for federal employees, the Federal Employees Health Benefits Program (FEHBP), cover psychiatric illnesses in ways equivalent to medical care. While federal and state policymakers pursued parity initiatives at federal and state levels between 1961-2006, the first major federal parity initiative passed Congress in 2008.[56] The

[56] The success of parity advocates in 2008 follows a long line of state and federal parity activities. In 1961, President Kennedy ordered the U.S. Civil Service Commission to require the health insurer for federal employees, the Federal Employees Health Benefits Program (FEHBP), cover psychiatric illnesses in ways equivalent to medical care. In the 1970s and 1980s, parity efforts were contained mainly in state legislatures with statutes establishing minimum benefits for alcohol use, drug use, and mental health (Laudicina, Loseleben, and Pardo 2000). After a series of legislative attempts beginning in 1992, Congress passed the Mental Health Parity Act of 1996, which required group health plans with fifty or more employees to apply the same lifetime and annual dollar limits to mental health benefits as those applied to medical and surgical benefits. Despite legislative impasse from 1997 to 2006, there were several other parity developments, including President Clinton's 1999 order to the Office of Personnel Management and budget to implement comprehensive mental health and substance abuse parity in the FEHBP. President Bush publicly stated his support for parity in mental health coverage when announcing his New Freedom Commission on Mental Health in 2002. Thus, the concept of parity had percolated in federal and state policy spaces for nearly fifty years before the 2008 law (Barry, Huskamp, and Goldman 2010).

Mental Health Parity and Addiction Equity Act of 2008 (federal parity law) aimed to eliminate the historical difference in insurance coverage between medical and surgical benefits and mental health and substance use disorder coverage. The law required some insurance plans offering mental health and substance use disorder benefits to provide coverage comparable to benefits for other medical conditions. While the original law only applied to private insurers supplied by employers with more than fifty employees, the Children's Health Insurance Program Reauthorization Act of 2009 and the Affordable Care Act of 2014 expanded parity protections to CHIP, individual and small group plans, and all Medicaid plans (Barry et al. 2016; Barry, Huskamp, and Goldman 2010).

Researchers attribute the passage of the 2008 federal parity law after years of gridlock to several factors. First, new evidence emerged allaying concern regarding the cost of parity, indicating that managed care would make expanding mental health benefits more affordable.[57,58] Second, members of the House – Patrick Kennedy (D-RI) and Jim Ramstead (R-MN) – and Senate – Pete Domenici (R-NM), Paul Wellstone (D-MN), and Edward Kennedy (D-MA) – with personal or family experiences with mental illness and substance use disorders championed the parity initiative. Finally, policymakers pursued separate political strategies in the House and Senate with the aim of gaining passage in each chamber and then accommodating differences

[57] Managed care controls costs by shifting from demand-side (e.g., cost-sharing, benefit limits) to supply-side (e.g., utilization review) mechanisms. Research showed that, on average, managed care reduced mental health spending by 25 percent (Barry, Huskamp, and Goldman 2010).

[58] Since mental health coverage was first offered in the 1950s by major medical insurers, insurers feared that intensive and ongoing psychotherapy would drive up premiums. Further, they also were worried about adverse selection – persons needing mental health services would be more likely to select plans offering extensive mental health coverage, increasing prices. Starting in the 1990s, policymakers and foundations funded research to assess the cost of parity, including an evaluation of parity in all in-network services offered by the FEHBP. New evidence emerged, suggesting that managed care would make expanding mental health benefits more affordable. Specifically, managed care would not substantially increase spending but was associated with reductions in out-of-pocket costs (Barry, Huskamp, and Goldman 2010).

between the bills during final negotiations (Barry, Huskamp, and Goldman 2010; P. J. Kennedy and Fried 2016).[59]

In the wake of the 2008 federal parity law's passage, policy entrepreneurs attempted to expand the concept of parity beyond insurance by creating the behavioral health equivalent of a federally qualified health center (health center). Health centers are outpatient clinics providing comprehensive primary care and enabling services in areas designated by the Department of Health and Human Services (HHS) as "medically underserved." The 1,400 health centers operating today provide care using a sliding fee scale based on a patient's ability to pay (Health Resources & Services Administration 2022). The federal government subsidizes health center care delivery through enhanced Medicaid reimbursement, grant opportunities, and reduced prescription drug costs. Beginning as a War on Poverty demonstration project, living largely "in the shadows of the health care system,"[60] the George W. Bush administration began a massive expansion of the program that continues today. The program has benefitted from periods of Democratic and Republican support, and today is typically characterized as a bipartisan policy area (Mickey 2012; Skinner and Wright 2022).[61]

[59] In the Senate, senators developed a bill that accommodated employer and insurance interests, including the requirement that health plans would decide the diagnoses covered by parity, as opposed to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The House bill was more expansive, applying to all DSM conditions and in- and out-of-network coverage. In conference, the House bill dropped the requirement that insurers cover all DSM disorders, and the Senate bill extended benefits to include out-of-network care and allowed states to impose more stringent parity requirements. After the parity bill stalling between June and September 2008 after a failed attempt to enact party as a rider to legislation extending tax breaks, the parity law eventually became the rider for the bailout package. Indeed, "…the parity law was passed as 'sweetener' to this unpopular but momentous law'" (Barry, Huskamp, and Goldman 2010, 423).

[60] Importantly, unlike the community mental health center program, the health center's initiative survived the 1981 Reagan block granting, though budget cuts led to the closure of 25% of the health centers (Skinner and Wright 2022)

[61] Mickey (2012) attributes Republican support for the health centers program beginning in the early 2000s to their ability to use health centers to circumvent systemic reform to the health care system. The Democratic relationship with the health centers program has undergone ebbs and flows. After preventing the reduction and elimination of the program during decades of proposed Republican budget cuts and block grant proposals, the Democrats were largely ambivalent toward health centers under the Clinton administration, until the Obama and Biden administrations began to view health centers as essential to eliminating health disparities, filling behavioral health provider shortages, and addressing the COVID-19 pandemic (Skinner and Wright 2022).

The objective of the 2009 Excellence in Mental Health Act was to attach community mental health to the bipartisan health centers program using the parity vehicle. The bill achieved this by creating a new community mental health provider – FQBHCs – and integrating FQBHCs into many of the federal financing programs available to health centers.[62] In Table 5.1, I present the provisions within the versions of the Excellence in Mental Health Act introduced before Newtown that extended eligibility for a health center financing programs to include FQBHCs. All versions of the Excellence in Mental Health Act, except the 2009 bill, incorporated FQBHCs into Medicaid special payment rules for health centers that require state Medicaid programs to reimburse health centers using a prospective payment system, where each center receives a predetermined per-visit rate based on the cost of services for Medicaid patients.[63] Five of the seven iterations required Medicaid cover FQBHC services under the 1950(a) medical assistance service requirements.[64] Three versions of the Excellence in Mental Health Act – S. 4038, S. 2247, and H.R. 5989 – extended eligibility for the 340B drug pricing program to include

[62] The bills replaced the community mental health center model within the Community Mental Health Services Block grant with FQBHCs.

[63] Section 1902(bb) of the Social Security Act requires state Medicaid programs to pay health centers (and rural health clinics) using a special cost-related payment formula called a PPS. The PPS requires state Medicaid programs to pay health centers the same payment for Medicaid patients regardless of the diagnosis, providers involved, or services delivered. The rate is updated annually to reflect medical inflation and the costs of new Medicaid-covered services. The purpose of this payment program is to reduce the diversion of funds from other grant programs to support the operation and care for persons that are uninsured and underinsured to subsidize low Medicaid payments or lack of Medicaid coverage for some services (National Association of Community Health Centers 2017). The current PPS was established in 2000 by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (Consolidated Appropriations Act 2001 2000; Rosenbaum et al. 2019). States have some flexibility in designing health center Medicaid payments. Indeed, state Medicaid agencies and their health centers may develop and agree to use alternative payment methodologies instead of the PPS. However, to receive federal financial support, models must pay at least the PPS rate and must maintain the basic protections against revenue shortfalls that led to the PPS.

[64] Specifically, Section 1905(a) of the Social Security Act defines the services a state Medicaid program must provide to mandatory and optional eligibility groups. The Omnibus Budget Reconciliation Act of 1989 mandated Medicaid programs cover health center services (Gurny, Hirsch, and Gondek 1992; Omnibus Budget Reconciliation Act of 1989 1989). The Excellence in Mental Health Act extended these mandatory services to include services delivered by FQBHCs.

FQBHCs.[65] And, S. 4038 added FQBHCs to a list of providers, including health centers, that were the priority population for regional centers of health information technology (American Recovery and Reinvestment Act of 2009 2009). These provisions demonstrate that the original goal of the Excellence in Mental Health Act was to build the behavioral health equivalent of a health center.[66]

Table 5.1: Federally Qualified Behavioral Health Center Provisions Within the Excellence in Mental Health Act

	H.R. 3200	**H.R. 5636**	**S. 4038**	**H.R. 2954**	**S. 2257**	**S. 2474**	**H.R. 5989**
Introduction Year	2009	2010	2010	2011	2012	2012	2012
Medicaid PPS	0	1	1	1	1	1	1
1950(a) medical assistance services	0	0	1	1	1	1	1
340B program	0	0	1	0	1	0	1
Health information technology	0	0	1	0	0	0	0

The policy design of this version of the Excellence in Mental Health Act represented a substantial transformation from existing community mental health policy. The bills extended the health centers program to a new policy area – community mental health – by creating a new provider: FQBHCs. FQBHCs, like health centers, would provide comprehensive health services to any individual regardless of ability to pay, and the federal financing programs for health centers would support this broad mandate. The program was nationwide and permanent. The

[65] The 340B program allows health centers and other entities treating low-income and uninsured patients to purchase outpatient prescription drugs at a substantial discount (Veterans Health Care Act of 1992 1992).

[66] These versions of the Excellence in Mental Health Act also contained financing provisions that did not relate to health centers. Most notably, the bills created a construction and modernization grant program for facilities providing community-based mental health and substance use disorder services. Interestingly, this is the only provision where the eligible entity was a state or an Indian tribe, not a FQBHC. Specifically, eligible entities were state recipients of the community mental health services block grant, a substance abuse prevention and treatment block grant, or an Indian tribe or tribal organizations. Interested eligible entities would submit an application to the Secretary detailing their construction or modernization plans. States could then award a maximum of fifteen percent of the total grant as sub-grants to FQBHCs for construction, expansion, and facilities and equipment purchases. In the application, eligible entities committed to making non-federal contributions at a 50-50 matching rate to the federal contribution.

bills imposed no restrictions on where FQBHCs could be located.[67] Indeed, any non-profit organization or unit of a local government in any state could apply to become an FQBHC. Further, the Excellence in Mental Health Act contained no expiration date, meaning that Congress would have to pass another law to eliminate the FQBHC program.

However, the Excellence in Mental Health Act bills before Newtown received next to no political attention and support. No bill left committee. Not a single Republican sponsored any iteration of the legislation. Only one version had more than 10 Democratic sponsors (H.R.2954 2011). Further, as noted in Chapter 4, lawmakers released few political statements related to community mental health, totaling 16 floor remarks and 2 press releasees.

This lack of political attention and support is likely due to the other health policy consuming political attention between the passage of the 2008 Federal Parity Law and the December 2012 shooting at Sandy Hook Elementary School: The Patient Protection and Affordable Care Act (ACA). The ACA became law in March 2010 after an extraordinary policymaking process. A confluence of factors brought the bill to enactment (e.g., millions of Americans losing their jobs and health coverage following the 2007-2009 Great Recession, Barack Obama's 2008 presidential victory, the widening of Democratic control in the House, the rare filibuster-proof Democratic majority in the Senate) but not without immense political controversy and partisanship: critics claimed that the law established "death panels," and the bill passed without a vote of a single Republican lawmaker. While supporters reasonably expected the controversy and partisanship to dissolve after the bill's passage, the ACA remained the focus of intense conflict (Hacker and Pierson 2018). While repeal efforts continued for five years until a 2017 bill fell just short of passage in the Republican-controlled Senate, the object of ACA

[67] This differs from the health center model, which requires that health centers be located in a medically underserved area or serve a population classified as medically underserved (Rural Health Information Hub 2021).

debate between 2010 – 2012 was a legal challenge. Six months before the Newtown shooting, on June 28, 2012, the Supreme Court handed down their ruling in *National Federation of Independent Business v Sebelius*, effectively making the Medicaid expansion optional for states and dealing a significant blow to the law (Gostin 2012; Oberlander 2018, 2020).

Thus, before Newtown, lawmakers attempted to radically reform the federal approach to community mental health care by applying the recently successful parity concept to community mental health services. The Excellence in Mental Health Act created a new community mental health provider – FQBHCs – which, like health centers, would provide comprehensive health services to any individual regardless of ability to pay, and the federal financing programs for health centers would support this broad mandate. However, there was very little political attention interested in community mental health until the shooting at Sandy Hook Elementary School in Newtown, Connecticut on December 14, 2012 prioritized the problem of mental illness allegedly causing violence.

5.2 Excellence in Mental Health Act Design After Newtown

How did policy entrepreneurs adapt the design of the Excellence in Mental Health Act in response to new political attention to the perceived relationship between mental illness and violence after the Newtown shooting? Policy entrepreneurs adapted the policy to reflect new Republican interest in the problem of mental illness allegedly causing violence after Newtown. While the shooting in Newtown grew Republican and Democratic political interest in this problem, Newtown did not modify the fundamental difference in partisan preferences for public health policies. Overall, Democrats remain more likely to support expansions of public health

programs relative to Republicans.[68] To couple the Democratic Excellence in Mental Health Act with the heightened Democratic and Republican political attention to the problem garnering attention after Newtown, policy entrepreneurs needed to adjust the bill to reflect Republican public policy preferences. Politicians achieved this by converting the program to a geographically and temporally limited Medicaid Demonstration, separating it entirely from the health centers program, and devolving most regulatory authority to state entities.

Newtown increased Republican interest in the problem of mental illness allegedly causing violence. Prominently, in January 2013, one month after Newtown, House Energy and Commerce Committee Chairman Fred Upton (R-MI) and Oversight and Investigations Subcommittee Chairman Tim Murphy (R-PA) announced that the oversight committee would spearhead an investigation into the relationship between mental illness and violence:

> The events in Newtown, Connecticut, have pushed mental health to the forefront, providing an opportunity to have a constructive discussion on a subject that has often been ignored… The string of attacks in Newtown, Aurora, Tucson, and at Virginia Tech force us to ask what we can do as a nation to care for and treat those who suffer from mental illnesses. Our committee has jurisdiction over the key federal departments and agencies who play a role in mental health research and care. We must seek to gain a better understanding of societal factors, potential causes, and their overall impact upon outbreaks of violence. Mental illness is a difficult subject and there are no easy answers,

[68] For instance, partisanship is an important component of why so many states rejected to create their own health insurance exchanges and expand Medicaid under the Patient Protection and Affordable Care Act (Grogan et al. 2020; Jacobs and Callaghan 2013; D. K. Jones 2017; D. K. Jones, Bradley, and Oberlander 2014; D. K. Jones, Singer, and Ayanian 2014). Republicans are more likely than Democrats to propose block grants, which limit federal expenditure by providing state and local governments a set amount for public health programs over matching structures, where the federal financial contribution is a percentage of state expenditures (Conlan 1998; Grogan and Rigby 2009). Republican governors were slower to adopt social distancing policies than Democrats in response to the COVID-19 pandemic (Adolph et al. 2021). It is important to note that research also demonstrates that partisanship is an incomplete explanation of many public health policy outcomes. For instance, D. K. Jones (2017) finds that Republican lawmakers were hardly unanimous in rejecting legislation that established a state exchange. Grogan and Rigby (2009) show that partisanship does not predict political support for block grants after implementation. While I do not investigate intraparty differences here, I acknowledge the likely within party variation that exists despite these interparty generalizations.

but it is important to have an honest discussion out in the open (House Committee on Energy and Commerce 2013d).

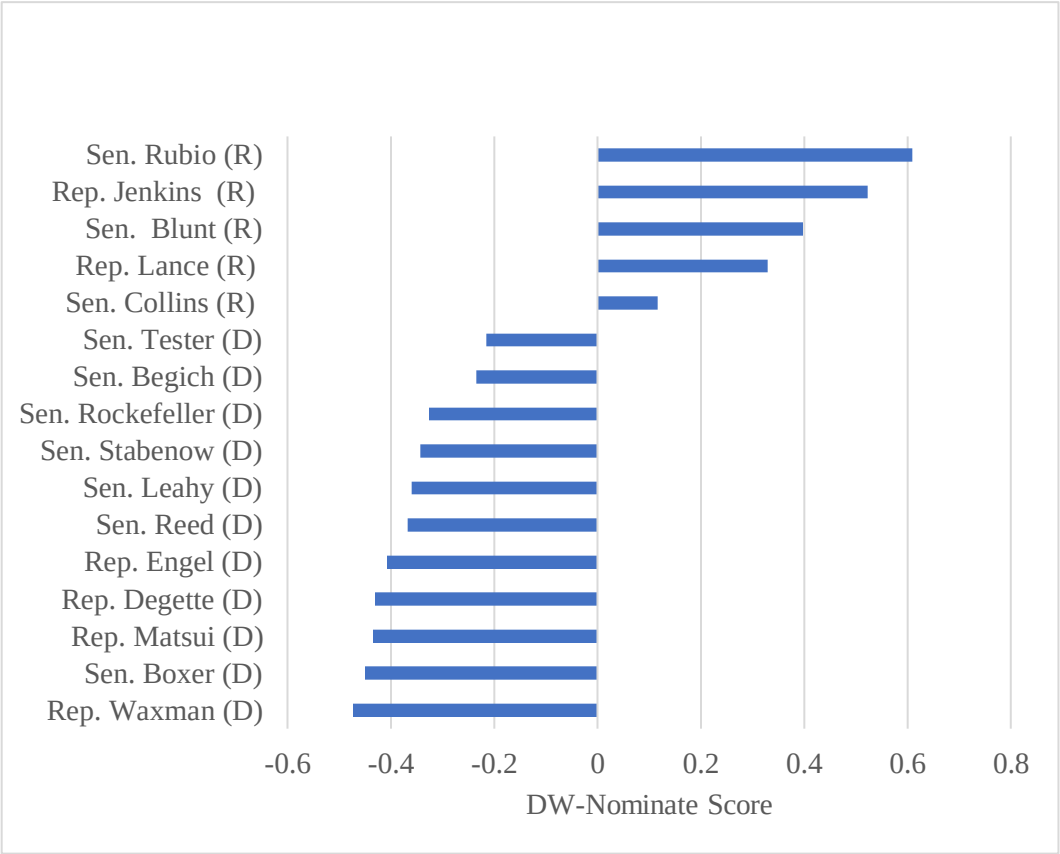
The committee's work included various activities.[69] For instance, the committee requested information from Health and Human Services on steps taken to assess and improve the mental health system in the wake of previous mass violence (House Committee on Energy and Commerce 2013f). They scheduled a forum for March 5, 2013 to explore the relationship between serious mental illness and violence with leading mental health experts, including the Director of the National Institute on Mental Health, the Executive Director of the National Alliance on Mental Illness, and several family members of persons with mental disorders (House Committee on Energy and Commerce 2013g, 2013b). Chairman Murphy and Ranking Member, Diana DeGette (D-CO), sent a letter to HHS, asking for clarification on several questions regarding challenges integrating mental health records into the National Instant Criminal Background Check System (NICS) because of federal privacy protections (House Committee on Energy and Commerce 2013e).

This increase in Republican attention to the problem of mental illness allegedly causing violence sparked by Newtown resulted in new, limited support for the first versions of the Excellence in Mental Health Act introduced after the mass shooting. The bills – S. 264 and H.R. 1263 – introduced in March and April of 2013 contained the FQBHC program described in the previous section. As a reminder, politicians used the parity strategy to create a nationwide, permanent FQBHC as an expansion of the health center programs. Figure 5.1 compares the DW-

[69] Other activities included a request that the Office of Management and Budget provides a list of all federal mental health research, prevention, and treatment programs (House Committee on Energy and Commerce 2013a). The committee held a hearing on how the privacy rule may "hinder patient care and public safety" (House Committee on Energy and Commerce 2013h). And on, June 14, 2013, Representatives Murphy and DeGette requested the Government Accountability Office review the federal government's mental health programs and examine specific grants awarded to states, communities, and organizations (House Committee on Energy and Commerce 2013c).

Nominate scores for the original House and Senate sponsors of the Excellence in Mental Health Act introduced in February and March of 2013.[70] DW-Nominate scores use roll call votes to estimate an ideological score for lawmakers. A score of -1 corresponds to the most liberal member of Congress, and a score of 1 corresponds to the most conservative member. While there remained more Democratic than Republican sponsors, Figure 5.1 demonstrates that sponsors represent a range of ideological orientations across and within parties.

Figure 5.1: DW-Nominate Scores for Original Sponsors of H.R. 1263 & S. 264



Note: A score of -1 corresponds to the most liberal member of Congress, and a score of 1 corresponds to the most conservative member.

[70] The 10 original sponsors included Democratic Senators Debbie Stabenow, Jack Reed, Barbara Boxer, John D. Rockefeller, Jon Tester, Mark Begich, and Patrick Leahy, and their Republican colleagues, Roy Blunt, Marco Rubio, and Susan Collins. Senator Debbie Stabenow, Senator Jack Reed, and Senator Richard Blumenthal were the only sponsors of previous iterations of the Excellence in Mental Health Act. Introduced on March 22, 2013, H.R. 1263 had 51 sponsors, including four Democratic original sponsors (i.e., Rep. Doris Matsui, Rep. Diana DeGette, Rep. Eliot Engel, and Rep. Henry Waxman) and two Republican original sponsors (Rep. Leonard Lance and Rep. Lynn Jenkins). The previous House version of the Excellence in Mental Health Act in 2012 had eight sponsors, all of whom were Democrats.

Importantly, these bills introduced the four member coalition that would become the champions of the Excellence in Mental Health Act and future bills aiming to expand the program within the Excellence in Mental Health Act (i.e., the Excellence in Mental Health and Addiction Treatment Expansion Act introduced before Parkland and Uvalde). Senator Blunt (R-MO) joined Senator Stabenow (D-MI) as the Senate champions. While Senator Stabenow was the primary sponsor on two of the three versions of the senate bill before Newtown, S. 264 in February 2013 is the first bill with both Senator Blunt and Stabenow's sponsorship. Similarly, Representative Lance (R-NJ) joined his colleague Representative Matsui (D-CA) as the House champion of the Excellence in Mental Health Act. Representative Matsui served as the primary sponsor or a sponsor on each House version of the Excellence in Mental Health Act before Newtown. H.R. 1263 in March 2013 is the first with Representative Lance and Matsui's sponsorship. These four lawmakers would become the core bipartisan foundation of legislative support for the Excellence in Mental Health Act and later related bills.

Despite establishing this core bipartisan group, Democratic support substantially exceeded that of Republicans in the first versions of the Excellence in Mental Health Act introduced after Newtown. Only 4, 9.0% of the 45 Republican senators, and 6, or 3.0% of the 234 Republican members of the House, sponsored these bills.[71] Thus, even though some Republicans publicly demonstrated their support for the Excellence in Mental Health Act through sponsorship, the majority were not interested in supporting this version of the bill.

[71] The Republican senators sponsoring S. 264 were Blunt, Collins, Rubio, and Murkowski, and the Republican members of the House sponsoring H.R. 1263 were representatives Jenkins, King, Lance, Paulsen, Rogers, and Runyan.

It was not until a year after Newtown that a substantial number of Republicans backed a version of the Excellence in Mental Health Act. A third of Republican representatives (78) and almost a fifth of Democratic representatives (38) sponsored H.R. 3717, introduced two days before the year anniversary of the Newtown shooting. The timing was by no means coincidental. In his statements introducing the bill in Congress, Representative Murphy began his remarks: "Mr. Speaker, in a couple of days we will have a moment of silence in respect and memory of the victims of Sandy Hook Elementary. We need to take those moments to pause, reflect, and pray. However, afterwards, we cannot be silent on the need to get something done, on the need to pass comprehensive and meaningful legislation, and the need to help the mentally ill" (The Helping Families in Mental Health Crisis Act; Congressional Record Vol. 159, No. 176 2013).

Why did Republicans change their mind that the Excellence in Mental Health Act was part of the solution to addressing the alleged relationship between mental illness and violence? Policy entrepreneurs grew the coalition supporting the Excellence in Mental Health Act by accommodating Republican policy preferences for a substantially curtailed bill design.[72] Democrats and Republicans have different preferences regarding public health. Generally, Democrats are more likely to support reforms that expand public health access than Republicans (Adolph et al. 2021; Conlan 1998; Grogan et al. 2020; Grogan and Rigby 2009; Jacobs and Callaghan 2013; D. K. Jones 2017; D. K. Jones, Bradley, and Oberlander 2014; D. K. Jones, Singer, and Ayanian 2014). Policy entrepreneurs changed the design of the Excellence in Mental Health Act to attract new Republican members in three ways. First, H.R. 3717 and all subsequent iterations of the Excellence in Mental Health Act introduced in 2014 converted the nationwide,

[72] It is important to note that the access, service, and coordination eligibility criteria applied to the provider created by the Excellence in Mental Health Act remained the same as those of previous versions of the Excellence in Mental Act.

permanent FQBHC program into a Medicaid Demonstration of severely limited scope. The Medicaid Demonstration limited the number of states that could participate in the program and decreased the program's length. Specifically, states would submit applications to Health and Human Services (HHS) to participate in the Medicaid Demonstration. In their applications, states would list organizations and attest that these entities met the provider criteria specified in federal law. HHS would then choose states to participate in the Medicaid Demonstration.

During the five months between when lawmakers introduced the first version of the Medicaid Demonstration in H.R. 3717 and the bill's passage on April 1, 2014, policy entrepreneurs continually reduced the program's scope (see Table 5.2). While the first bill limited the number of states that could participate in the Demonstration to ten, the enacted bill, H.R. 4302, further reduced the number of participating states to eight. In addition, H.R. 3717 set a Demonstration length expiring at five years, but subsequent bills decreased the length first to four and then to two years in the final law. These limitations on geography and length created a community behavioral health program that was far more limited in reach than the original Excellence in Mental Health Act, which faced no geographic or time restrictions.

Table 5.2: CCBHC Medicaid Demonstration Program Provisions

Bill Number	Introduction Date	Last Action	Number of States	Demonstration Years
H.R.3717	Dec.12, 2013	Apr. 3, 2014	10	5
S.1871	Dec.19, 2013	Jan. 16, 2014	10	5
S.2110	Mar. 11, 2014	Mar. 12, 2014	8	4
S.2122	Mar. 12, 2014	Mar. 13, 2014	8	4
S.2157	Mar. 25, 2014	Mar. 26, 2014	8	4
H.R.4302 (P.L.113-93)	Mar. 26, 2014	Apr.1, 2014	8	2

The second way policymakers accommodated Republican public policy preferences was by abandoning the parity strategy. Before Newtown, policymakers used parity as the vehicle to expand federal involvement in community mental health by creating the behavioral health

equivalent of a health center and incorporating this new entity into federal health center programs. Beginning with H.R. 3717, policymakers institutionally segregated this new behavioral health entity from health centers by eliminating their eligibility for health center programs. Most visibly, while H.R. 3717 maintained the FQBHC name, the 2014 versions of the Excellence in Mental Health Act changed the name to CCBHCs. The name "federally qualified behavioral health center" superficially implies that FQBHCs are the behavioral health version of a federally qualified health center. CCBHC, on the other hand, does not contain an explicit nomenclature link.

Institutionally, the bills also removed CCBHCs from health center programs. For instance, CCBHCs were no longer eligible for the 340B drug pricing program. The bills also eliminated CCBHC eligibility for the health center Medicaid special payment. In the first two iterations of the demonstration (H.R. 3717, S. 1871), policymakers removed the provision incorporating CCBHCs into the section of federal statute that lists the provider types eligible for the health center Medicaid payment but added a provision requiring the HHS Secretary to establish a prospective payment system for CCBHCs in the same manner as these payments. Indeed, the provision directly references the federal code that contains the special Medicaid payment (Consolidated Appropriations Act 2001 2000). The subsequent versions of the Excellence in Mental Health Act removed all reference to the health centers' payment system (S. 2110, S.2122, S.2157, H.R. 4302). The revised provision states that the Secretary "shall issue guidance for the establishment of a PPS that shall only apply to medical assistance for mental health services furnished by a certified community behavioral health clinic participating in a demonstration program." This evolution signals that lawmakers decided to maintain the PPS as

the financial mechanism to support the comprehensive CCBHC model. However, they did not want to tie it institutionally or explicitly to health centers.

Finally, the Excellence in Mental Act versions containing the Medicaid Demonstration devolved most certification powers to states. Whereas previous iterations of the bill assigned regulatory and attestation powers exclusively to federal entities, the Demonstration split this authority between federal and state governments. Before the Demonstration, all regulatory and certifying authority resided with the federal government - "the Administration shall certify, and rectify at least every 5 years, federally qualified community behavioral health centers as meeting the criteria specified in this subsection." The Medicaid Demonstration, on the other hand, divides regulatory responsibility between federal and state governments. While the federal government sets the floor for CCBHC criteria, state governments can impose additional requirements. Further, the Excellence in Mental Health Act that became law completely removed the federal government's CCBHC certification role, only requiring that states attest in their application materials to participate in the Demonstration that entities that would receive Medicaid special payment would meet the federal CCBHC criteria.

This adaptation in policy proposal design to accommodate new Republican political attention to the problem of mental illness allegedly causing violence after Newtown made the Excellence in Mental Health Act one of the most popular provisions within the bipartisan H.R. 3717: the bill introduced at the one year anniversary of Newtown. The bill contained a package of individual mental health programs within 135 pages of legislative text, including the adapted Excellence in Mental Health Act. Many of the other provisions were controversial. Several provider and patient organizations, including Mental Health America, the Bazelon Center for Mental Health Law, the Children's Mental Health Network, the National Coalition for Mental

Health Recovery, and the National Disability Rights Network, opposed provisions of H.R. 3717 that eliminated essential Substance Abuse and Mental Health Services Administration programs and changed privacy laws in ways that, they viewed, were detrimental to the patient-provider relationship. They also rejected the bill's establishment of grant programs to expand involuntary outpatient treatment: a civil court procedure where a person is court-mandated to follow a specific treatment plan, often including medication (Bazelon Center for Mental Health Law 2013; Children's Mental Health Network 2013; Mental Health America 2013). However, a non-controversial provision was the inclusion of the 2013 Excellence in Mental Health Act. In an advocacy organization's press release criticizing Murphy's bill titled "Mental Health America Faults Rep. Tim Murphy's Legislation for Jeopardizing Role for Consumers and Their Recovery," they also praise Representative Murphy for including the CCBHC program (Mental Health America 2013).

In summary, by the year anniversary of Newtown, policy entrepreneurs adapted the design of the Excellence in Mental Health Act to reflect the increase in political attention to the problem of mental illness allegedly causing violence produced by Newtown. The Newtown shooting dramatically increased Democratic and Republican attention to the perceived link between mental illness and violence. However, this interest did not translate into substantial Republican policy proposal support until policy entrepreneurs adapted the proposal's design to accommodate Republican policy preferences for small government programs with devolved regulatory responsibilities. Specifically, policy entrepreneurs converted the Excellence in Mental Health Act from a nationwide, permanent program primarily regulated by the federal government to a geographically and temporarily limited Medicaid Demonstration primarily regulated by states. In sum, the evidence demonstrates that policy entrepreneurs responded by

modifying an existing policy proposal in response to an increase in political attention following a focusing event, specifically new Republican interest in the alleged link between mental illness and violence.

5.3 The Excellence in Mental Health and Addiction Treatment Expansion Act Before and After Uvalde

Thus far, I have exclusively examined whether policy entrepreneurs adapted policy proposal design in response to Newtown increasing political attention to the problem of mental illness allegedly causing violence. In this section, I demonstrate that policy entrepreneurs adapted the design of a related community mental health policy proposal after the mass shooting in Uvalde, Texas. A former student at Robb Elementary School fatally shot 19 students and two teachers and injured 17 others in Uvalde on May 24, 2022. Uvalde rapidly increased public and political attention to the same problem garnering attention after Newtown. Following the Uvalde shooting, a bipartisan group of senators initiated negotiations to develop a bill, the Bipartisan Safer Communities Act, "…to protect America's children, keep our schools safe, and reduce the threat of violence across our country" (Murphy 2022a).[73] The bill would contain an adapted version of the Excellence in Mental Health and Addiction Treatment Expansion Act, which expanded the CCBHC program within the Excellence in Mental Health At.

While people involved in government had attempted to expand the 2014 Excellence in Mental Health Act for eight years, they were unsuccessful until the Uvalde mass shooting and the Bipartisan Safer Communities Act. Beginning in 2016, lawmakers supported legislation that

[73] The group included Senators Chris Murphy (D-Conn.), John Cornyn (R-Texas), Thom Tillis (R-N.C.), Kyrsten Sinema (D-Ariz.), Richard Blumenthal (D-Conn.), Roy Blunt (R-Mo.), Cory Booker (D- N.J.), Richard Burr (R-N.C.), Bill Cassidy (R-La.), Susan Collins (R-Maine), Chris Coons (D-Del.), Lindsey Graham (R-S.C.), Martin Heinrich (D-N.M.), Mark Kelly (D-Ariz.), Angus King (I-Maine), Joe Manchin (D-W.Va.), Rob Portman (R-Ohio), Mitt Romney (R-Utah), Debbie Stabenow (D-Mich.), and Pat Toomey (R-Pa.).

expanded the Medicaid Demonstration program within the Excellence in Mental Health Act, which was eventually adopted in 2014, largely because of the coupling process discussed previously and described in detail in forthcoming sections. Specifically, the bill – initially titled the Expand Excellence in Mental Health Act before becoming the Excellence in Mental Health and Addiction Treatment Expansion – added more states to the Medicaid Demonstration and extended the program's expiration. While lawmakers introduced this policy proposal ten times before Uvalde in four Congresses, and each bill had extensive bipartisan support among legislators, lawmakers did not pass the bill until it was incorporated into the Bipartisan Safer Communities Act in 2022 (P.L. 117-159).

Table 5.3 compares each iteration of the Excellence in Mental Health and Addiction Treatment Expansion before and after Uvalde. The Table reveals that in negotiations to incorporate the expansion of the Excellence in Mental Health Act into the Bipartisan Safer Communities Act, policy entrepreneurs adapted the policy proposal. Before Uvalde, the bills added a set number of states to the Medicaid Demonstration for two years. After Uvalde, policy entrepreneurs modified the design of the expansion. First, the expansion would roll out slowly. The law limited the HHS Secretary to selecting ten states every two years beginning on July 1, 2024. Further, the law extended the Demonstration length. While previous iterations maintained the same length as the 2014 Excellence in Mental Health Act - states would participate in the Demonstration for two years – the new law extended the Demonstration length to four years.

Like Newtown, Table 5.3 demonstrates that policy entrepreneurs adapted the Excellence in Mental Health and Addiction Treatment Expansion Act following Uvalde. After Newtown, policy entrepreneurs converted the program within the Excellence in Mental Health Act from a nationwide, permanent program regulated by the federal government to a temporary Medicaid

Demonstration primarily regulated by states. After Uvalde, policy entrepreneurs modified the Excellence in Mental Health expansion within the Excellence in Mental Health and Addiction Treatment Expansion Act to a delayed rollout over a longer time horizon.

Table 5.3: Policy Design of Excellence in Mental Health and Addiction Treatment Expansion Act

	Introduced	Last Action	New demo. states	Length of new demo.	Sponsors	
					D	R
Before Uvalde						
S.2525	2/9/16	2/9/16	16	2	1	1
H.R.4569	2/12/16	2/19/16	32	2	1	1
H.R. 4567	2/12/16	2/19/16	16	2	9	8
S. 1905	10/2/17	10/2/17	11	2	2	2
H.R. 3931	10/3/17	10/6/17	11	2	19	15
H.R. 1767	3/14/19	6/4/19	11	2	72	22
S.824	3/14/19	3/14/19	11	2	8	8
S. 2069	6/15/2021	6/15/2021	Any	2 years or through 9/30/2023	9	9
H.R.4323	7/1/2021	7/2/2021	Any	2 years or through 9/30/2023	33	14
H.R.7116	3/17/2022	3/28/2022	Any	2 years or through 9/30/2023	55	2
After Uvalde						
PL 117-159	10/5/2021	6/25/2022	10 states, every 2 years	4 years	0	1

Note: D = Democrat; R = Republican.

5.4 Agenda Setters and Newtown and Uvalde

This chapter, in combination with the previous two, demonstrates that people involved in government coupled substantial community mental health policy proposals – the Excellence in

Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act – following the shootings in Newtown and Uvalde rapidly increased public and political attention to the problem of mental illness allegedly causing violence. Politicians adapted proposal rhetoric, and policy entrepreneurs adapted proposal design in response to increased attention to the problem. Taken together, the chapters demonstrate that political actors responded to the incentive to pursue coupling through proposal modification; they adapted policy proposal rhetoric and design to enhance the likelihood of the coupled policy progressing to the top of the legislative agenda.

But why did the focusing events of Newtown and Uvalde produce coupling? I argue that policy proposal support from relevant agenda setters was critical to the decision to engage in two mechanisms involved in coupling after a focusing event. Lawmakers occupying positions afforded immense agenda controls have powers that allow them to prevent undesirable bills from reaching the floor or expedite the bills through the legislative process (Campbell, Cox, and McCubbins 2002; Cox and McCubbins 2005; Jenkins and Monroe 2016). Coupling aims to increase the likelihood that a bill climbs the legislative agenda: the list of items actively being decided upon. I predict that people involved in government will only engage in coupling if agenda setters influencing mental health policy support the bill, for instance, by sponsoring the legislation or using rhetoric to signal their support for the policy. By displaying their support, politicians and policy entrepreneurs are more likely to engage in the costly coupling process because there is a lower likelihood that an agenda setter will use their agenda powers to block a bill she supports from reaching the floor.

Relevant agenda setter support following Newtown and Uvalde provides evidence defending my prediction. In Table 5.4, I present these findings, beginning with the Excellence in

Mental Health Act. The Table contains the positions with control over the bill's legislative process. This includes the majority leader, whip, and the chairs of the Senate and House committees or subcommittees where the Excellence in Mental Health bills were referred. The Senate versions of the Excellence in Mental Health Act were referred to the Senate Finance Committee or the Health, Education, Labor, and Pensions Committee, and the House versions of the bill were assigned to the Energy and Commerce Subcommittee on Health. Table 5.4 contains the lawmakers occupying these positions between the first introduction of the Excellence in Mental Health Act after Newtown and the bill's enactment date of April 1, 2014. In the Sponsor column, I list whether any of these agenda setters sponsored a version of the Excellence in Mental Health Act before or after Newtown, signaling support for the bill. I also list the date of sponsorship to indicate whether the agenda setter provided their support before the coupling process concluded in the House on December 12, 2013 and in the Senate on December 19, 2013: the dates when lawmakers introduced the first adapted version of the Excellence in Mental Health Act.

Table 5.4: Support for Excellence in Mental Health Act Among Agenda Setters

	Name	**Sponsor**	**Sponsorship date**
Senate – Coupled: 12/19/13			
Majority Party	Democrats (53 seats)		
Leader	Harry Reid	No	No
Whip	Richard Durbin	No	No
Committee chair (Finance)	Max Baucus Ron Wyden	Yes	12/19/13 2/7/13, 3/11/14, 3/26/14
Committee chair (HELP)	Tom Harkin	No	No
House – Coupled: 12/12/13			
Majority Party	Republicans (234 seats)		
Speaker	John Boehner	No	No
Whip	Steve Scalise	No	No
Committee chair	Fred Upton	No	No
Subcommittee chair	Joseph Pitts	Yes	3/26/14

Note: Help = Health, Education, Labor, and Pensions

I begin with the Senate. Table 5.4 reveals that Senator Max Baucus (D-MT) and Ron Wyden (D-OR), Chairs of the Senate Committee on Finance during the 113th Congress (January 3, 2013 – January 3, 2015), supported versions of the Excellence in Mental Health Act before the coupling process concluded.[74] Senator Wyden was a S. 264 sponsor, introduced not two months after Newtown, which contained the original national, permanent FQBHC program.[75] Both Senators Baucus and Wyden supported the adapted versions of the Excellence in Mental Health Act. Indeed, Senator Baucus was the sole sponsor of the bill containing the first coupled version of the Excellence in Mental Health Act (S. 1871 2013). After Senator Wyden assumed the chair position on February 6, 2014, he became the only sponsor of subsequent versions of this legislation.

Moreover, statements from other lawmakers indicated that Senator Wyden used positive agenda controls to move the Excellence in Mental Health Act through the legislative process. The two champions of the Senate bill, Roy Blunt (R-MO) and Debbie Stabenow (D-MI), both thanked Senator Wyden for his support, stating, "I wish to thank Senator Ron Wyden, who has been there since day one and now as chairman of the Finance Committee has been unequivocal in his passionate support for what we are doing. I wish to thank Chairman Wyden for his leadership and support" (Minimum Wage Fairness Act--Motion to Proceed; Congressional Record Vol. 160, No. 51 2014)

The story in the House is slightly more complicated. Table 5.4 reveals that the Chair of the House Energy and Commerce Subcommittee on Health, Representative Joseph Pitts (R-PA),

[74] Senator Max Baucus (D-MT) was the original chair of the Senate Finance committee during the 113th Congress. After President Obama nominated Senator Baucus as the next ambassador to China, Senator Wyden assumed the chair position on February 6, 2014 (Davis 2013)

[75] He was also the lead sponsor on S. 2110 and S. 2157: both large bills containing Excellence in Mental Health introduced in March 2014.

was the lead sponsor of the comprehensive bill that contained the Excellence in Mental Health Act, H.R. 4302, that became law on April 1, 2014. However, he signaled his support for the bill after the lawmakers introduced an adapted version of the Excellence in Mental Health Act in the House on December 12, 2013. Who, then, within House leadership provided support for the Excellence in Mental Health Act before coupling, encouraging the political actors responsible for this process to begin adaptation? Tim Murphy (R-PA), Chair of the Energy and Commerce Oversight and Investigations Subcommittee, was crucial to the decision to engage in coupling, and Chairman Pitts was critical to the decision to continue the coupling process.

As discussed previously, in January 2013, one month after Newtown, House Energy and Commerce Committee Chairman Fred Upton (R-MI) and Oversight and Investigations Subcommittee Chairman Tim Murphy (R-PA) announced that the oversight committee would spearhead an investigation into the relationship between mental illness and violence. The bill developed through this committee, led by Representative Murphy, contained the first coupled version of the Excellence in Mental Health Act, indicating that Representative Murphy was directly involved in the initial coupling process.

Representative Murphy then worked with Representative Pitts, along with other leaders, to continue to adapt the Excellence in Mental Health Act, so that it reached the top of the legislative agenda. When Representative Murphy introduced the coupled version of the Excellence in Mental Health Act (H.R. 3717) at the year anniversary of Newtown, Congressional attention was also focused on another healthcare policy: the Medicare sustainable growth rate (SGR).[76] While the bills approached fixing the SGR differently - some required cuts, others

[76] The SGR, enacted by the Balanced Budget Act of 1997 and eliminated in 2015 when President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, intended to constrain Medicare spending through adjustments to annual physician fee updates.[76] On December 26, 2013, President Obama postponed a 24.4% cut to

repealed the SGR entirely, and some delayed the SGR triggered decrease – the majority and minority party leaders who sponsored the bills, including Senator Ron Wyden (Chair of Senate Finance Committee), Senator Orrin Hatch (Ranking Member of Senate Finance Committee) and Representative Joseph Pitt (Chair of Energy and Commerce Subcommittee on Health), attached an adapted version of the Excellence in Mental Health Act to five of the eight bills.[77] Indeed, party leadership differed on how to fix the SGR but agreed on including a version of the Excellence in Mental Health Act in any legislation. As Senator Ben Cardin (D-MD) stated on the floor, "I thank Senator Blunt and Senator Stabenow for their leadership on the mental health demonstration program that is in this—whatever bill we pass it will be in—because it is absolutely essential we address the growing problems in our community health networks" (Protecting Access to Medicare Act of 2014; Congressional Record Vol. 160, No. 51 2014).

Senator Cardin was correct. Agenda setters incorporated the adapted version of the Excellence in Mental Health Act into the final version of the Protecting Access to Medicare Act. And Representative Pitts, Chairman of the House Energy and Commerce Subcommittee on Health, was the bill's lead sponsor. Representative Murphy explicitly thanked Representative Pitts for including an adapted version of the Excellence in Mental Health Act in the Protecting Access to Medicare Act, which would eventually become law (Helping Families in Mental Health Crisis Act of 2014 2014). Table 5.4 and these statements together demonstrate the importance of support from majority leaders in the coupling and legislative process related to the Excellence in Mental Health Act after Newtown.

physician reimbursement until April 1, 2014 (Hirsch and Manchikanti 2014). Given the proximity of the cuts, lawmakers began introducing and debating bills related to the SGR at the same time as lawmakers considered H.R. 3717. Between December 2013 and March 2014, lawmakers introduced eight of the so-called "doc-fix" bills.

[77] It is important to note that the Excellence in Mental Health Act is one of two programs from the 135 pages of Helping Families in Mental Health Crisis Act that made it into the "doc-fix" law.

In Table 5.5, I turn to Uvalde. The table identifies the agenda setters who had the power to impact the legislative process related to the Excellence in Mental Health and Addiction Treatment Expansion Act. The Senate versions of this bill were referred to the Senate Finance Committee, and the House versions of the bill were assigned to the Energy and Commerce Subcommittee on Health. Like Table 5.4, Table 5.5 contains the lawmakers occupying these position when Congress adopted the adapted version of the Excellence in Mental Health and Addiction Treatment Expansion Act as a provision within the Bipartisan Safer Communities Act on June 25, 2022. The sponsor column lists whether the lawmakers sponsored any version of the bill, and the sponsorship date column displays the dates when lawmakers sponsored these bills to indicate whether sponsorship happened before or after the coupling process concluded in the Senate on June 21, 2022 and the House on June 24, 2022: the dates when lawmakers introduced the first adapted version of the Excellence in Mental Health and Addiction Treatment Expansion Act. Again, the table reveals that leaders in both chambers – Senator Ron Wyden (D-OR), Chair of the Senate Committee on Finance, and Representative Anna Eshoo (D-CA), Chair of the Energy and Commerce Subcommittee on Health – supported the legislation.

Table 5.5: Support for Excellence in Mental Health and Addiction Treatment Expansion Act Among Agenda Setters

	Name	**Sponsor**	**Sponsorship date**
Senate – Coupled: 6/21/2022			
Majority Party	Democrats (48 seats)		
Leader	Charles Schumer	No	No
Whip	Richard Durbin	No	No
Committee chair	Ron Wyden	Yes	3/14/2019, 6/15/2021
House – Coupled: 6/24/2022			
Majority Party	Democrats (222 seats)		
Speaker	Nancy Pelosi	No	No
Whip	James Clyburn	No	No
Committee chair	Frank Pallone, Jr.	No	No
Subcommittee chair	Anna Eshoo	Yes	2/12/2016

In addition, to support from leadership, the Excellence in Mental Health and Addiction Treatment Expansion Act benefitted from its main senatorial supporters – Senators Roy Blunt (R-MO) and Debbie Stabenow (D-MI) – being involved in the negotiation process that led to the Bipartisan Safer Communities Act. Indeed, Senators Blunt and Stabenow were two of 20 senators involved in the bill's development. This positioning potentially allowed Senators Blunt and Stabenow to prioritize including their policy, an expansion of the 2014 Excellence in Mental Health Act, over other policy alternatives in the Bipartisan Safer Communities Act.

In summary, the results support that lawmakers with control over the advancement of community mental health legislation influenced the decision to couple these bills with the problem prioritized by Newtown and Uvalde. Agenda setters, specifically the chairs of the committees and subcommittees involved in the legislative process by which the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act traversed, sponsored at least one iteration of the bill before the coupling process concluded. This support signaled that these lawmakers would not use their agenda control to block the bill from reaching a floor vote. In fact, statements from other legislators thanking these individuals for their support suggest that they may have deployed positive agenda controls to expedite the bills through the legislative process. In all, the analysis reveals that relevant agenda setters likely influenced the decision of political actors to couple the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act with the problems capturing public and political attention after Newtown and Uvalde.

5.5 Conclusion

Political actors engaged in the coupling of the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act after Newtown and Uvalde. Both

mass shootings heightened public and political attention to the problem of mental illness allegedly causing violence, incentivizing politicians and policy entrepreneurs to adapt the rhetoric and design of these existing community mental health policy proposals so that they became the perceived solution to the problem garnering attention after each event. Indeed, political actors engaged in the two mechanisms involved in coupling after a mass shooting. But why did Newtown and Uvalde catalyze the coupling process? While all mass shootings motivate coupling by providing a problem political actors can hook to their legislative proposals, carrying it through the legislative process, nothing guarantees coupling. Indeed, coupling offers incentives, but political actors must act to take advantage of these incentives.

I find that members of the majority party who have control of the legislative agenda related to community mental health were crucial to the decision to engage in coupling after Newtown and Uvalde. These agenda setters, specifically committee and subcommittee chairs, sponsored versions of the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act before the coupling process began, signaling to the people responsible for coupling that they would not use negative agenda control to prevent the bill from reaching the floor. Further, I find some evidence demonstrating that agenda setters may have used positive agenda controls to expedite the bills through the legislative process. Taken together, these lawmakers, because of their agenda powers, likely influenced the decision of political actors to couple substantial community mental health reforms with the problem of mental illness allegedly causing violence after Newtown and Uvalde.

However, there remains a hole in my argument. I have not explored a negative case or a mass shooting that shares similar properties to Newtown and Uvalde that did not lead to coupling. The following chapter offers one such example: the mass shooting in Parkland, Florida

on February 14, 2018. Political actors did not couple the Excellence in Mental Health and Addiction Treatment Expansion Act – the same bill coupled (and adopted) after Uvalde – following the shooting in Parkland despite lawmakers introducing the legislation only four months before the Parkland shooting. Put another way, politicians and policy entrepreneurs did not adapt a nearly identical bill to the one coupled after Uvalde to align with the problem prioritized by both events. I will show that the absence of support from relevant agenda setters was crucial to the decision by political actors not to initiate the coupling process after Parkland.

Chapter 6 Dismissing Coupling After Parkland

The previous chapters demonstrated that political actors coupled two substantial community mental health policies – the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Act – with the problem prioritized after the mass shootings in Newtown, Connecticut on December 14, 2012 and in Uvalde, Texas on May 24, 2022. I showed that political actors engaged in the two mechanisms involved in coupling – rhetorical and design adaptations – to align these existing policies with the problem prioritized after each event – mental illness allegedly causing violence – increasing the likelihood that these bills would progress through the legislative process toward enactment. In addition, I find that support from members of the majority party who substantially influence the community mental health agenda, known as agenda setters, played an essential role in the coupling process after the Newtown and Uvalde shootings. These lawmakers possess controls that allow them to influence which bills advance to the top of the legislative agenda. Displays of support from these leaders signal that they will likely not use these controls to prevent the coupled policy from reaching the Senate or House floor for a vote. I find that support from individuals occupying these positions, specifically, the chairs of the committees and subcommittees where community mental health bills were referred, was critical to the decision to initiate and continue the coupling process.

While I find consistency in the importance of agenda setters in the Newtown and Uvalde case, it does not confirm my hypothesis that this support was crucial to the coupling process following a focusing event (Collier 2011). Indeed, I require additional evidence from a mass

shooting, in many ways like Newtown and Uvalde, that did not result in coupling. If relevant agenda setters supported the community mental health policy, then the case refutes my hypothesis, as coupling did not occur even though agenda setter support was present. However, if this support was absent, I gain additional, strong evidence that the support from lawmakers with agenda controls influenced the decision to couple community mental health policy reforms with the problem prioritized by the mass shooting. This chapter provides this example, examining the impact of agenda setter support on the coupling process after a school mass shooting that did not lead to the adaptation of a community mental health policy: the shooting at Marjory Stoneman Douglas Highschool in Parkland, Florida on February 14, 2018 where a gunman killed 17 people and injured 17 others.

The lack of coupling after Parkland is particularly surprising given that Parkland shared many similarities with the shootings in Newtown and Uvalde (see Table 6.1). First, the three mass shootings have similar profiles. All three shootings were mass casualty events in school settings where the perpetrator was a male former student. Second, all three shootings rapidly increased public and political attention to the problem of mental illness allegedly causing violence. Third, lawmakers had introduced a similar, substantial community mental health policy proposal – the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Act – months before each shooting. These policies created or substantially expanded a Medicaid program that financially supported a new community mental health provider type: certified community behavioral health clinics. Lawmakers introduced the Excellence in Mental Health Act six months before Newtown, and legislators introduced the Excellence in Mental Health and Addiction Treatment Expansion Act four months before Parkland and two months before Uvalde. Fourth, before or immediately after each school

shooting, the same bipartisan champions, Senators Blunt (R-MO) and Stabenow (D-MI) and Representatives Matsui (D-CA) and Lance (R-NJ), led a bipartisan coalition of lawmakers sponsoring the Excellence in Mental Health Act or the Excellence in Mental Health and Addiction Treatment Expansion Act.

Table 6.1: Characteristics of Newtown, Parkland, and Uvalde Shootings

	December 14, 2012: Newtown, CT	**February 14, 2018: Parkland, FL**	**May 24, 2022: Uvalde, TX**
Coupling			
Rhetoric adapted	Yes	No	Yes
Design adapted	Yes	No	Yes
Coupling	Yes	No	Yes
Potential explanations			
Shooting profile	Elementary school 26 individuals killed Shooter: Male, former student	High school 17 individuals killed Shooter: Male, former student	Elementary school 21 individuals killed Shooter: Male, former student
Problem	Mental illness allegedly causing violence	Mental illness allegedly causing violence	Mental illness allegedly causing violence
Community mental health policy	Excellence in Mental Health Act	Excellence in Mental Health and Addiction Treatment Expansion Act	Excellence in Mental Health and Addiction Treatment Expansion Act
Bipartisan sponsors	Yes	Yes	Yes
Gun agenda	Yes	Yes	Yes
Seats			
House	House: *234 R*, 201 D	House: *241 R*, 194 D	House: *222 D*, 212 R
Senate	Senate: *53 D*, 45 R, 2 I	Senate: *51 R*, 47 D, 2 I	Senate: *48 D*, 50 R, 2 I
Explanation			
Agenda setter support			
House	Yes	No	Yes
Senate	Yes	No	Yes

Note: R = Republican; D = Democrat. Italicized is the party in control. I operationalize seats as the partisan distribution within each chamber. I define gun agenda as periods when gun control is at the top of the legislative agenda. I define leader support as community mental health policy support from agenda setters. For Newtown, I report the bipartisan sponsors, house seats, senate seats, and leader support for the 113th Congress, even though Newtown occurred at the very end of the 112th Congress. This is because the majority of the coupling process happened during the 113th Congress, which was sworn in less than a month after Newtown.

Fifth, gun control reforms climbed the legislative agenda after all three shootings, demonstrating that the presence or absence of a legislative push for gun control cannot explain the decision to engage or not pursue coupling of community mental health policy. Finally, the party with the majority of seats does not explain the decision to engage in coupling. Beginning with the House, the Republican party controlled the chamber at the time of Newtown (234 seats to 201 Democratic seats) and Parkland (241 seats to 194 Democratic seats), so House control cannot explain the difference in coupling. In the Senate, since neither the Excellence in Mental Health Act nor the Excellence in Mental Health and Addiction Treatment Expansion Act was exempt from the filibuster, and neither party had a filibuster-proof majority, simply possessing more seats cannot explain the decision to engage in coupling after Newtown and Uvalde, but not Parkland.

However, Parkland's political context differed from the mass shootings in Newtown and Uvalde in an important way. At the time of Newtown and Uvalde, members of the majority party who have control of the agenda related to community mental health supported the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act before the coupling process concluded. Indeed, as demonstrated in the previous chapters, the chairs of the committees where these bills were assigned sponsored the legislation, contributing to the decision to engage and progress through the coupling process. Further, statements from other lawmakers explicitly thanked the committee chairs for moving the bills through the legislative process. In contrast, the lawmakers in leadership positions at the time of Parkland never displayed support for the Excellence in Mental Health and Addiction Treatment Expansion Act. Indeed, no lawmaker in the positions of party leader, whip, committee chair, or subcommittee chair at the time of Parkland sponsored any version of the legislation or released a

statement about community mental health. This difference in support from agenda setters between Newtown and Uvalde versus Parkland demonstrates that lawmakers with relevant agenda controls were crucial to the decision to engage in the coupling of community mental health policy after a mass shooting.

The following chapter proceeds as follows. First, I remind the reader that the mass shooting in Parkland in February 2018 meets my definition of a focusing event. Second, I demonstrate that politicians and policy entrepreneurs did not couple the Excellence in Mental Health and Addiction Treatment Expansion Act with the problem prioritized by Parkland. Finally, I provide evidence that the lawmakers occupying the positions with relevant agenda controls when Parkland occurred did not offer public support for the Excellence in Mental Health and Addiction Treatment Expansion Act. The chapter provides evidence that (1) people involved in government did not engage in coupling after Parkland, and (2) support from agenda setters explain why politicians and policy entrepreneurs elected not to pursue this coupling process.

6.1 Parkland as a Focusing Event

In Chapter 2, I defined a focusing event as a rare, sudden event that rapidly increases public and political attention to a problem, so much so that the problem becomes a priority issue. The mass shooting at Marjory Stoneman Douglas High School in Parkland, Florida on February 14, 2018 meets this definition. A shooter killed 17 people and injured 17 others. The event abruptly increased public and political attention to the problem of mental illness allegedly causing violence. *The New York Times* wrote that "…social media posts and interviews with people who knew him revealed that… (he) had a history of mental health and behavioral problems…" (Mazzei, Bogel-Burroughs, and Madigan 2022). *The Wall Street Journal* reported

that an investigation by a Florida child social service agency determined that the shooter was "clinically depressed" (Avila 2018).

Table 6.2 presents the number of articles from *The Wall Street Journal* and *The New York Times* and statements in the Congressional Record that imply a potential relationship between mental illness and violence. The table displays that Parkland meets my definition of a focusing event that rapidly increased public and political attention to the perceived problem of mental illness allegedly causing violence. Public attention increased dramatically. The number of articles containing this link in *The Wall Street Journal* increased from zero in the month before to 16 in the month after Parkland. *The New York Times* also released many more statements in the month after (17) than the month before (1) the shooting. In addition, political attention to mental illness allegedly causing violence grew; the number of statements in the Congressional Record increased 2.5-fold from 18 statements in the month before to 47 statements in the month after.

Table 6.2: Number of Articles and Statements Discussing Both Mental Illness and Violence

	The Wall Street Journal	***The New York Times***	**The Congressional Record**
90th percentile	5	7	30
Month before	0	1	18
Month after	16	17	47

Note: The 90th percentile means that 90% of months have fewer articles or statements than the number listed in the cell. I identified news articles using the following search strategy. In the New York Times and Wall Street Journal Databases in ProQuest News & Current Events, I searched the following text string: ("mental illness" OR "mental health") AND ("violence" OR "violent" OR "gun" OR "shooting"). I limited the search to anywhere in the article except the full text, meaning that the search included the title, abstract, subject, and other summary. I further limited the search by excluding articles with a source type other than "Newspaper" and articles not written in English. I identified statements in the Congressional Record by searching the same text string in the Congressional Record search of congress.gov.

The results demonstrate that the mass shooting in Parkland on February 14, 2018 meets my definition of a focusing event. The tragedy rapidly increased public and political attention to the problem of mental illness allegedly causing violence, so much so that it became a priority

concern. In the following section, I examine whether political actors responded to the Parkland shooting by adapting the Excellence in Mental Health and Addiction Treatment Expansion Act to align with the problem prioritized after the focusing event.

6.2 The Absence of Coupling

Political actors did not attempt to couple community mental health policy with the problem prioritized by Parkland: mental illness allegedly causing violence. Coupling after a focusing event involves two adaptations of a policy proposal. First, focusing events incentivize politicians to adapt proposal rhetoric to reflect the increase in public attention to the problem. Second, these events motivate policy entrepreneurs to adapt policy proposal design to accommodate the increased political attention to the problem after the event. Political actors did not initiate either adaptation after Parkland.

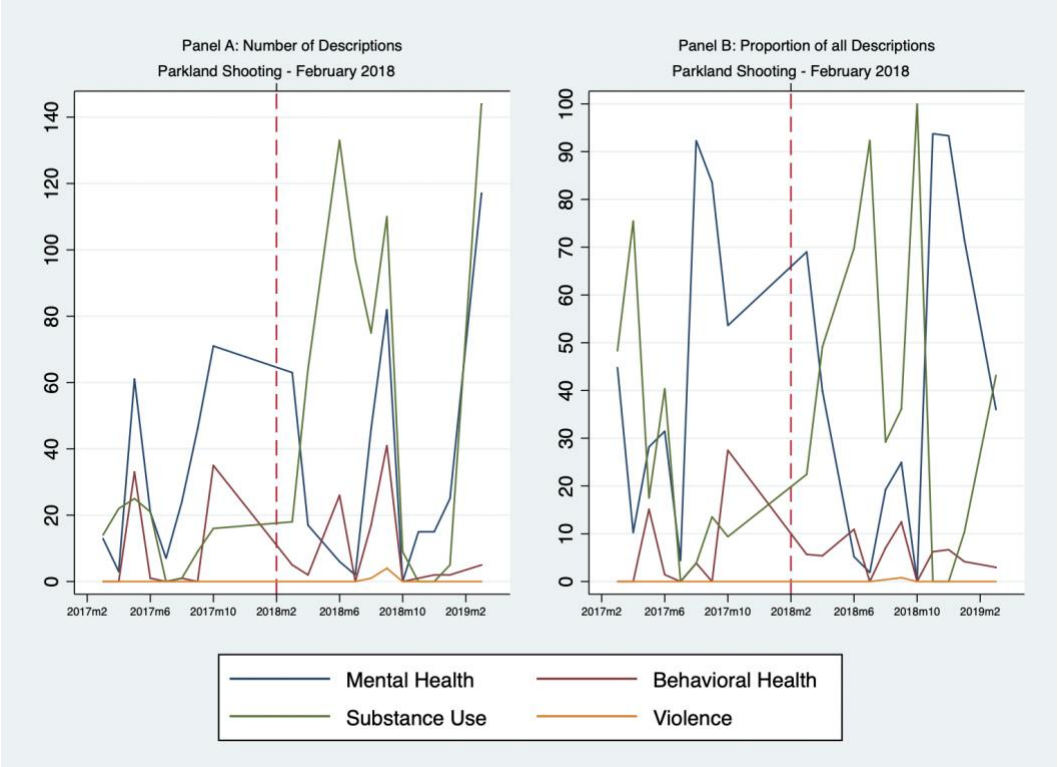
6.2.1 Policy Proposal Rhetoric

Politicians did not adapt their rhetoric related to the Excellence in Mental Health and Addiction Treatment Act or other minor community mental health policy proposals in response to heightened public attention to mental illness allegedly causing violence after Parkland. In Chapter 3, I demonstrated that politicians did not increase their use of violence rhetoric after the Parkland shooting, but how did politicians describe community mental health policy in the absence of these descriptions? Perhaps they changed their rhetoric in other ways important to explaining why politicians did not engage in coupling after Parkland.

Figure 6.1 displays the number and proportion of references associated with the four topics discussed in statements related to community mental health policy.[78] As a reminder, politicians commonly used four topics when describing community mental health policy during the period under study. These topics were mental illness, substance use, behavioral health, and violence. Like Figure 3.5, the yellow line shows that violence constitutes 0% of all descriptions in the 6 months before and after the Parkland shooting ($p=0.51$).[79] There is also no change in the proportion of behavioral health references. The red line displays that behavioral health constitutes an average of 15.7% of all descriptions in the six months before Parkland and 7.1% in the six months after ($p=0.07$). However, politicians changed their use of mental health and substance use descriptions between the six months before and after Parkland. Specifically, while the percentage of all descriptions that were mental health decreased after Parkland (before: 67.9%; after: 26.5%; $p<0.01$), the proportion of descriptions that were substance use increased from 10.2% to 45.5% ($p<0.01$).

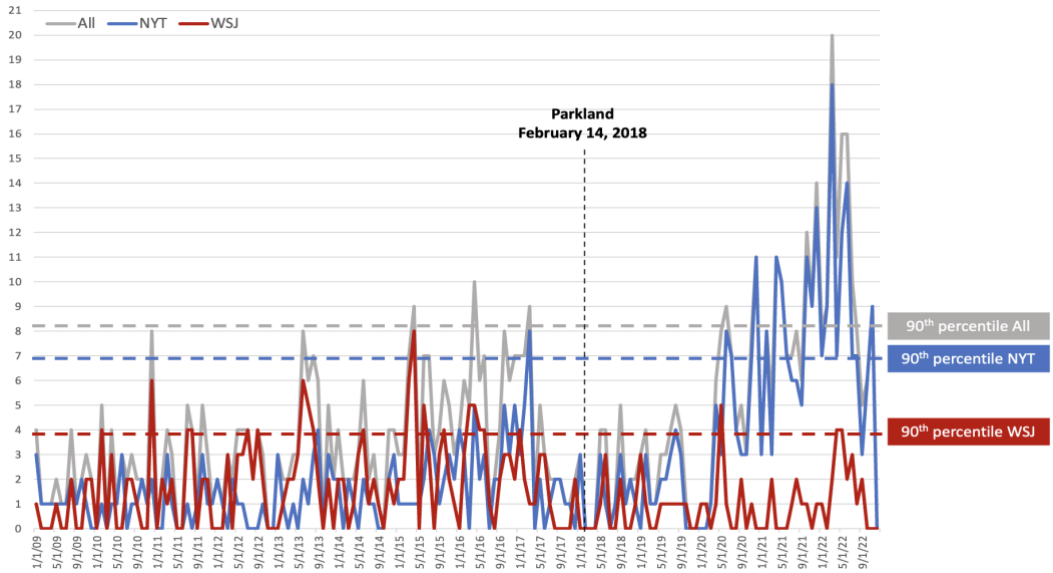
[78] Please refer to Appendix C for my methodological approach for coding press releases and floor remarks related to community mental health and Appendix E for the codebook.
[79] I produced the p-value from a t-test comparing the average proportion of violence descriptions in the six months before and after Parkland. I used the same statistical test to compare the average proportion of descriptions that were behavioral health, mental health, and substance use.

Figure 6.1: Descriptions of Community Mental Health Policy Proposals Before and After Parkland



What explains the substitution of mental health for substance use rhetoric in political statements related to community mental health? A focusing event increasing public and political attention to the problem of substance use was not responsible for the increase in substance use rhetoric. Figure 6.2 displays the number of newspaper articles that mention both mental illness and substance use between January 1, 2009 and December 31, 2022. The figure shows that in the six months after Parkland, there was no increase in public attention to the problem of mental illness and substance use. Indeed, the number of articles is far below the 90th percentile of articles for all months for both *The Wall Street Journal* and *The New York Times*.

Figure 6.2: Public Attention to the Link Between Mental Illness and Substance Use Before and After Parkland Shooting

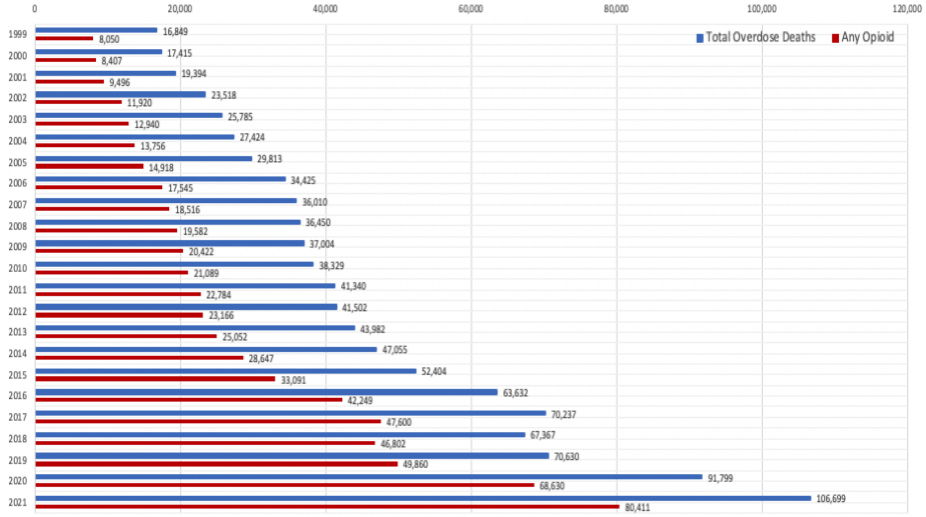


Note: NYT: *The New York Times*. WSJ: *The Wall Street Journal*. I identified news articles using the following search strategy. In the New York Times and Wall Street Journal Databases in ProQuest News & Current Events, I searched the following text string: ("mental illness" OR "mental health") AND ("drug" OR "overdose" OR "substance use" OR "addiction" OR "opioid"). I limited the search to anywhere in the article except the full text, meaning that the search included the title, abstract, subject, and other summary. I further limited the search by excluding articles with a source type other than "Newspaper" and articles not written in English. I identified statements in the Congressional Record by searching the same text string in the Congressional Record search of congress.gov.

If a focusing event was not responsible for the rise in substance use rhetoric in community mental health, why, then, did politicians increase their use of substance use descriptions after Parkland? Indicators are another mechanism that may turn public and political attention to a problem. Indicators, such as disease mortality rates, consumer prices, persons enrolled in entitlement programs, costs of government programs, and many others, provide information on the extent of an issue (Kingdon 1984). Various governmental reports and academic publications have acted as indicators, revealing an increasing trend in deaths due to opioid overdose since 1999 (see Figure 6.3). In 2017, 70,237 individuals died from a drug overdose. Opioids are substantially responsible for the current drug epidemic, accounting for

47,600 deaths in 2017, a nearly six-fold increase from 1999 (National Center for Health Statistics 2020).[80]

Figure 6.3: Overdose Deaths and Overdose Deaths Involving an Opioid



Note: Author's analysis of data from the National Cener for Health Statistics (2020).

Public attention to the problem of substance use, particularly opioid use, is high. The majority of the American public view the opioid crisis as a serious public health problem.[81] Barry et al. (2016) conducted the first national public opinion study about American opinions of opioid pain reliever use. Researchers asked participants to rate the seriousness of 12 health issues, including prescription pain reliever use, finding that 58% of respondents ranked prescription pain reliever use as a very serious or extremely serious health issue.[82] A Pew

[80] Deaths due to any drug have since risen to 106,699 in 2021, and deaths due to opioids have risen to 80,411, a nearly 10-fold increase from 1999. This is not to say that deaths due to other drugs have not also increased; drug overdose deaths involving cocaine, psychostimulants with abuse potential (e.g., methamphetamine), and cocaine have increased from 12,122 in 2015 to 53,495 in 2021 (National Institute on Drug Abuse 2023).

[81] It is important to note that public perceptions of the seriousness of the opioid epidemic co-exist with the persistence of substantial stigma toward individuals with substance use disorders. Indeed, public stigma toward people with these conditions remains high (Barry et al. 2014), and research finds that these stigmatizing views correlate with lower support for policies benefitting persons with substance use disorders (Kennedy-Hendricks et al. 2017).

[82] While respondents reported opioid pain reliever use as a very serious or extremely serious health issue, on par with alcohol use, tobacco use, mental illness, and gun violence, in the aggregate, it was ranked less serious than cancer, heart disease, illegal drug use, diabetes, and obesity (Barry et al. 2016).

Research Center (2018) report found that approximately 90% of Americans in rural, suburban, and urban areas viewed drug addiction as a major or minor problem. These findings persist across partisan groups; the Bipartisan Policy Center (2022) found that 66% of Democrats, 58% of Republicans, and 57% of Independents believe that the opioid crisis is a significant public health emergency.[83]

Politicians have responded to the increasing trend in overdose deaths and public attention to substance use through various initiatives. In September 2018, lawmakers increased funds for several mental health and substance use disorder programs, including community mental health, through an appropriations bill that narrowly avoided a government shutdown by two days (Pramuk 2018).[84] In press releases discussing the legislation, lawmakers discussed community mental health clinics as essential to combatting the opioid epidemic. For instance, Senator Roy Blunt (R-MO) claimed that appropriations for the provider created through the 2014 Excellence in Mental Health Act – passed after the mass shooting in Newtown – would go "to some of the areas in our state that have been hit hardest by the opioid epidemic… With today's announcement more people will be able to get the help they need before it's too late" (Blunt 2018). In a statement issued by Senator Tim Kaine (D-VA), the Excellence in Mental Health Act Medicaid Demonstration is one of many listed under the heading of programs that "combat substance abuse" (Kaine 2018). Thus, the rise in substance use-related rhetoric after Parkland resulted from politicians adapting their descriptions of a policy with a community mental health

[83] Though, public opinion regarding the urgency of opioid use may be overstated. Blendon and Benson (2018) found that opioids ranked sixth on a list of 15 domestic policy issues that were possible Congressional and presidential priorities in 2017.

[84] Besides other mental health and substance use disorder programs, the bill provided $50 million for a grant program for entities that meet the certified community behavioral health clinic certification requirements established through the Excellence in Mental Health Act, which lawmakers passed after Newtown.

policy provision, an appropriations bill, with the public interest in the opioid crisis following years of indicators revealing rising deaths due to opioid overdose.

In summary, the Parkland shooting did not affect rhetoric describing the Excellence in Mental Health and Addiction Treatment Expansion Act and other minor community mental health policies. While Parkland increased public attention to the problem of mental illness allegedly causing violence, politicians did not respond to this increase by using more violence rhetoric. While I observed politicians heightened their use of substance use rhetoric after Parkland, this increase was coincidental. Put another way, the Parkland focusing event did not turn public attention to the problem of substance use, and consequently, Parkland could not motivate politicians to adapt their rhetoric to reflect the problem of substance use. Rather, the increase in policy proposal rhetoric related to substance use reflected politicians framing an appropriations bill with community mental health policy provisions as addressing the problem – revealed by indicators, not a focusing event – of rising drug overdose deaths. In all, this section demonstrates that politicians did not initiate the rhetorical component of the coupling process after Parkland.

6.2.2 Policy Proposal Design

The second adaptation involved in coupling incentivized by a focusing event relates to policy proposal design. Focusing events increase public attention to a problem and raise political attention to a problem. Consequently, these events motivate policy entrepreneurs to adapt policy proposal design to accommodate the politicians, and their partisan and ideological preferences, who are newly interested in the issue after the focusing event. Parkland increased political attention to the perceived problem of mental illness allegedly causing violence. In this section, I

demonstrate that policy entrepreneurs did not adapt the Excellence in Mental Health and Addiction Treatment Expansion Act after Parkland to accommodate this new political interest.

Beginning in 2016, the same bipartisan coalition of lawmakers who championed the Excellence in Mental Health Act introduced legislation that expanded the reach of the 2014 program. As a reminder of the previous chapter's discussion, following Newtown, Congress adopted the Excellence in Mental Health, which reversed a 30 year legacy of limited federal involvement in community mental health care. This policymaking process involved political actors coupling the Excellence in Mental Health Act with the problem garnering attention after the Newtown shooting – mental illness allegedly causing violence – contributing to this bill's progression through the legislative process toward enactment. Part of this coupling process involved policy entrepreneurs reducing the scope of the CCBHC program embedded within the Excellence in Mental Health Act to accommodate new Republican preferences in the problem prioritized by Newtown. Specifically, policy entrepreneurs converted the program from a nationwide, permanent program regulated by the federal government to a two year, eight state Medicaid Demonstration primarily regulated by states.

Two years after the Excellence in Mental Health Act's passage, lawmakers introduced legislation – the Excellence in Mental Health and Addiction Treatment Expansion Act – that aimed to expand the CCBHC program.[85] The same bipartisan champions of the Excellence in Mental Health Act – Senators Blunt (R-MO) and Stabenow (D-MI) and Representatives Matsui (D-CA) and Lance (R-NJ) – led a bipartisan coalition of lawmakers to introduce this legislation in the years before and after Parkland. The bills expanded the number of states who could

[85] The bill was initially titled the Expand or Extend Excellence in Mental Health Act, but lawmakers changed the name to the Excellence in Mental Health and Addiction Treatment Expansion Act in 2017.

participate in the program and the length of the Medicaid Demonstration. In Table 6.3, I provide an overview of these bills.

Table 6.3: The Design of the Excellence in Mental Health and Addiction Treatment Expansion Act

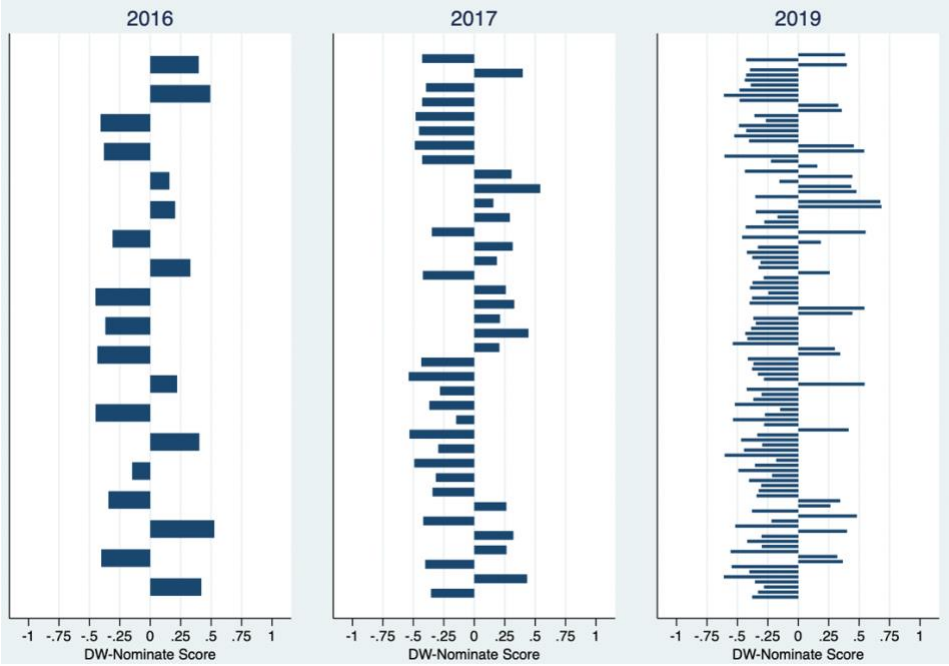
Bill number	First action	Last action	Added states	Total states	Added years	Total years	D	R
Before Parkland								
S.2525	2/9/16	2/9/16	16	24	0	2	1	1
H.R.4569	2/12/16	2/19/16	32	Any	3	5	1	1
H.R. 4567	2/12/16	2/19/16	16	24	0	0	9	8
S. 1905	10/2/17	10/2/17	11	29	1	3*	2	2
H.R. 3931	10/3/17	10/6/17	11	29	1	3*	19	15
After Parkland								
S.824	3/14/19	3/14/19	11	29	2	4*	8	8
H.R. 1767	3/14/19	6/4/19	11	29	2	4*	72	22

*Length of time for states already participating in the Demonstration, not added states.

Table 6.3 reveals that lawmakers introduced a version of the Excellence in Mental Health and Addiction Treatment Expansion Act four months before and 13 months after the Parkland shooting on February 14, 2018. The bills were remarkably similar. S.1905/H.R.3931 introduced in October 2017, and S. 824/H.R.1767 introduced in March 2019, added several states to the program created by the 2014 Excellence in Mental Health Act, so that nearly 60.0% of all states would be eligible to participate. The bills extended the program by three or four years. And lawmakers from both parties supported the legislation. The versions of the Excellence in Mental Health and Addiction Treatment Expansion Act (S. 824/H.4.1767) introduced after Parkland were more popular in that more Democrats and Republicans joined the coalition sponsoring the bills. Regardless, the sponsors of the 2016, 2017, and 2019 versions represent both parties and a range of political orientations within each party.

Indeed, Figure 6.4 illustrates this partisan and ideological diversity using DW-Nominate scores. DW-Nominate scores use roll call votes to estimate a lawmaker's ideological orientation. A score of -1 corresponds to the most liberal member of Congress, and a score of 1 corresponds to the most conservative member. Figure 6.4 demonstrates that lawmakers with a range of partisan and ideological preferences sponsored each iteration of the legislation before and after Parkland.

Figure 6.4: DW-Nominate Scores for Sponsors of The Excellence in Mental Health and Addiction Treatment Expansion Act (2017, 2019)



Note: A score of -1 corresponds to the most liberal member of Congress, and a score of 1 corresponds to the most conservative member.

Table 6.3 demonstrates that policy entrepreneurs did not adapt the Excellence in Mental Health and Addiction Treatment Expansion Act's design after Parkland. In 2014, lawmakers revolutionized federal investment in community mental health policy by enacting the Excellence in Mental Health Act following a coupling process triggered by the shooting in Newtown on December 14, 2014. The law reversed thirty years of limited federal involvement in community mental health care by creating a two year, eight state Medicaid Demonstration program to

financially support a new community mental health provider. Beginning in 2016, political actors aimed to expand the 2014 Demonstration by adding more states and extending the program's expiration date through the Excellence in Mental Health and Addiction Treatment Expansion Act. However, unlike the shooting in Uvalde in May 2022, the Parkland focusing event did not motivate policy entrepreneurs to adapt the design of this policy proposal in response to increased political attention to the problem that mental illness allegedly causes violence.

6.3 Other Mental Health Policies

The previous sections provided evidence that political actors did not couple the Excellence in Mental Health and Addiction Treatment Expansion Act with increased public and political attention to the problem of mental illness allegedly causing violence after the Parkland shooting. Focusing events incentivize both rhetorical and design coupling, and political actors initiated neither after Parkland. Politicians did not adapt proposal rhetoric by using more violence descriptions of the Excellence in Mental Health and Addiction Treatment Expansion Act after Parkland. In addition, policy entrepreneurs did not adapt the bill's design to accommodate the increase in political interest to the problem of mental illness allegedly causing violence. In sum, political actors did not couple the Excellence in Mental Health and Addiction Treatment Expansion Act with the problem prioritized after Parkland.

Perhaps people involved in government coupled another mental health policy with the problem capturing public and political attention after Parkland. An essential component of Kingdon's (1984) coupling concept is *alternative specification*, or the selection of a specific policy tool. For instance, in response to rising opioid overdose deaths, policy entrepreneurs may design proposals that increase punitive sanctions for drug-related crimes. Alternatively, they may design proposals that strengthen treatment for opioid addiction and enhance access to overdose

prevention measures. Policy entrepreneurs may design policy proposals that create new programs that are nationwide and permanent or geographically limited and temporary. Further, they may allocate no money, some, or a lot to implement the program. Applying the logic of alternative specification to the coupling of mental health policy proposals after Parkland, politicians and policy entrepreneurs may have selected an alternative mental health policy or another community mental health policy to couple with the problem prioritized by Parkland. I explore this possibility here.

I begin with mental health policies, regardless of whether they contain a community mental health component. Table 6.4 examines whether the Newtown, Parkland, and Uvalde shootings encouraged politicians to adapt their rhetoric about other mental health policy proposals. Specifically, I present the number of references to Newtown, Parkland, and Uvalde in discussions of significant mental health legislation that became law between 2009 – 2022. Table 6.4 reveals that lawmakers mentioned the Newtown shooting in discussions of the Excellence in Mental Health Act and the Helping Families in Mental Health Crisis Act, suggesting that the shooting in Newtown played a role in the policymaking process that resulted in these bills becoming laws. There is no mention of any mass shootings in discussions of the three laws passed between 2019 and 2021: the National Suicide Hotline Designation Act of 2020, Crisis Stabilization and Community Reentry Act, and the American Rescue Plan. While lawmakers referenced the shootings in Newtown and Parkland in discussions of the Bipartisan Safer Communities Act, they mentioned the tragedy in Uvalde double the number of times. This suggests that the Parkland focusing event did not motivate politicians to adapt rhetoric related to mental health policy, but Newtown and Uvalde did.

Table 6.4: References to Mass Shootings That Were Focusing Events in Discussions of Major Mental Health Policy Enactments, 2009-2022

		Newtown	Parkland	Uvalde
		12-Dec-12	14-Feb-18	24-May-22
Excellence in Mental Health Act/Protecting Access to Medicare Act	Apr. 1, 2014	5	-	-
Helping Families in Mental Health Crisis Act / 21st Century Cures Act	Dec. 13, 2016	8	-	-
National Suicide Hotline Designation Act of 2020	Oct. 17, 2019	0	0	-
Crisis Stabilization and Community Reentry Act	Dec. 31, 2020	0	0	-
American Rescue Plan	Mar. 11, 2021	0	0	-
Excellence in Mental Health and Addiction Treatment Expansion Act/Bipartisan Safer Communities Act	Jun. 25, 2022	10	10	17

Notes: I compiled the list of laws by gathering laws, except those related to appropriations, mentioned in blog posts by a major mental health advocacy organization – the National Council for Mental Wellbeing – between 2009 – 2022. To identify references to mass shootings, I searched the following search structure – "statute" AND "mass shooting" – in the Congressional Records search of congress.gov. For the statute component, I did not include the word "Act." For the laws passed on April 1, 2014 and December 13, 2016, I searched both the name of the standalone legislation and the name of the law it was incorporated into. The keywords used for Newtown were "Newtown" OR "Sandy Hook." The keywords used for Parkland were "Parkland" OR "Marjory." The keywords used for Uvalde were "Uvalde" OR "Robb."

I also examine whether politicians and policy entrepreneurs coupled other community mental health policies besides those related to the Excellence in Mental Health Act with the problem prioritized by Parkland. One bill impacting community mental health policy – the Consolidated Appropriations Act of 2018 (H.R. 1625 2018) – was introduced before Parkland on March 20, 2017 and enacted after the shooting on March 23, 2018. Policy entrepreneurs adapted the community mental health provisions within this bill after Parkland. Between the Senate passing the amended version of the bill on February 28, 2018 and the House passing the amended legislation on March 22, 2018, political actors added a provision that allocated $100,000,000 for a new grant program for certified community behavioral health clinics: the provider type created through the 2014 Excellence in Mental Health Act. While people involved

in government may have been motivated to add this provision during negotiations because of Parkland, I find no evidence of this in political rhetoric. Indeed, my review of 555 press releases and floor remarks related to community mental health between 2009 and 2022 revealed no statement connecting the creation of this grant program with Parkland or violence rhetoric generally.

In summary, I find no support that political actors coupled any mental health policy with the problem capturing public and political attention after Parkland: mental illness allegedly causing violence. Earlier, I detailed the absence of violence rhetoric describing community mental health policy before and after Parkland. Next, I showed that policy entrepreneurs did not adapt the design of the Excellence in Mental Health and Addiction Treatment Expansion Act – a bill that aimed to expand the Excellence in Mental Health Act to more states for more years – following Parkland. Finally, I demonstrated that people involved in government did not adapt the rhetoric or design of other community mental health or mental health policy after Parkland. I conclude that politicians and policy entrepreneurs did not modify mental health policy proposals, including the Excellence in Mental Health and Addiction Treatment Expansion Act, to align with the problem prioritized by the Parkland shooting.

6.4 Agenda Setters and Parkland

Thus far, this chapter has provided evidence that political actors did not pursue the coupling of the Excellence in Mental Health and Addiction Treatment Expansion Act after Parkland. Policy entrepreneurs did not increase their use of violence rhetoric, and politicians did not adapt policy proposal design in response to Parkland, heightening public and political attention to the problem of mental illness allegedly causing violence. In the following section, I examine why people involved in government did not initiate coupling after Parkland.

Specifically, I test my expectation that support from agenda setters contributed to the lack of policy coupling following Parkland.

I argue that agenda setters influence the coupling process because of their control over the legislative agenda: the list of items actively being decided upon by Congress. Through determining which bills are considered on the floor and under what procedures, members of the majority party who have great control over the legislative agenda can use these powers to prevent undesirable bills from reaching the floor or expedite bills through the legislative process (Campbell, Cox, and McCubbins 2002; Cox and McCubbins 2005; Jenkins and Monroe 2016). Since the goal of coupling is to increase the likelihood that a bill climbs the legislative agenda, I expect that people involved in government will only initiate coupling if agenda setters are invested in the policy, for instance, by sponsoring the legislation or using rhetoric to signal their support for the policy. Without this public investment, political actors perceive a greater chance that these lawmakers will use their agenda powers to block the bill from reaching the floor. Below, I find strong support for this prediction: the lawmakers occupying the positions with control over the legislative progression of the Excellence in Mental Health and Addiction Treatment Expansion Act did not support the bill.

Table 6.6 examines whether relevant agenda setters at the time of the Parkland shooting publicly supported any version of the Excellence in Mental Health and Addiction Treatment Expansion Act before and after Parkland. The Senate versions of the bills were assigned to the Finance Committee, and the House versions were referred to the Energy and Commerce Subcommittee on Health. In Table 6.6, I list the occupants of the chair positions of these committees and the lawmakers in other majority leadership positions. I then identified whether any of these members sponsored a version of the Excellence in Mental Health and Addiction

Treatment Expansion Act in the years before or within two years of Parkland. I also searched for whether or not any of the lawmakers made a floor remark related to community mental health during the period before or immediately after Parkland.

Table 6.5: Agenda Setter Support for the Excellence in Mental Health and Addiction Treatment Expansion Act

	Name	Sponsor	Statement
Senate			
Majority Party	Republican (51 seats)	No	0
Leader	Mitch McConnell	No	0
Whip	John Cornyn	No	0
Committee chair	Orrin Hatch	No	0
Subcommittee chair	-	-	-
House			
Majority Party	Republican (241 seats)	No	0
Speaker	Paul Ryan	No	0
Whip	Steve Scalise	No	0
Committee chair	Greg Walden	No	0
Subcommittee chair	Michael Burgess	No	0

The results within Table 6.6 are blunt. It reveals that not a single member of leadership publicly expressed support for any version of the Excellence in Mental Health and Addiction Treatment Expansion Act. Indeed, no party leader, whip, committee chair, or subcommittee chair (i.e., the people who have control over the bill's progression through the legislative process) sponsored any version of the legislation or released a statement about community mental health. This finding suggests that not a single member of leadership possessed an interest in using their agenda setting powers to promote the bills on the legislative agenda. Further, the lack of support may imply that leadership would use negative agenda powers to prevent the legislation from reaching the floor.

Some may find the lack of support from agenda setters surprising, given the bipartisan support from other party members. I showed in Table 6.3 and Figure 6.4 that Democrats and Republicans representing a range of ideological orientations sponsored each iteration of the

legislation. Indeed, lawmakers did not introduce a single bill without expansive bipartisan sponsorship. Taken together, the lack of leadership support but expansive bipartisan support among other party members suggests that the decision to pursue coupling depends on the unique agenda setting powers possessed by leadership, not simply possessing majority control.

In summary, Table 6.6 provides evidence in agreement with my prediction that political actors will not engage in coupling without policy proposal support from members of the majority party who have control of the legislative agenda related to community mental health . The objective of the two elements of the coupling process after a focusing event – adaptations in proposal rhetoric and design to align with the problem prioritized by the event – is to increase the likelihood the proposal reaches the top of the legislative agenda. Indeed, by adapting a policy proposal to become the solution to the problem prioritized by the focusing event, political actors offer a solution that addresses, or allegedly addresses, the problem, improving the chance that the bill will reach the floor vote. But politicians and policy entrepreneurs only perceive the potential public policy benefits outweighing the costs of the coupling process if agenda setters support the policy before the coupling process concludes. This support signals to the political actors responsible for coupling that leadership will not use their agenda powers to prevent the legislation from reaching the floor. Since the majority party leaders controlling the agenda relevant to community mental health at the time of Parkland offered no such support in the case of the Excellence in Mental Health and Addiction Treatment Expansion Act, I find further evidence that agenda setters were crucial to the decision to engage in the coupling of community mental health policy proposals with the problem prioritized by the Newtown, Parkland, and Uvalde shootings.

6.5 Conclusion

Despite having much of the same problem, policy, and political infrastructure as the tragedies in Newtown and Uvalde, political actors elected not to act on the incentives to pursue coupling after Parkland. All three mass shootings heightened public and political attention to the problem of mental illness allegedly causing violence. Political actors acted upon the incentives to align substantial community mental health policy reforms with this problem following Newtown and Uvalde. Indeed, politicians and policy entrepreneurs adapted the rhetoric describing and design of the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act to align with the problem garnering attention as a result of these shootings, contributing to the legislative enactment of these policies. In contrast, political actors did not pursue coupling of the same policy - the Excellence in Mental Health and Addiction Treatment Expansion Act – after Parkland. Why did Newtown and Uvalde catalyze the coupling process, but Parkland did not?

This chapter further supports my argument that agenda setters are critical to the decision to engage in the coupling of existing community mental health policy proposals with the problem prioritized after a mass shooting. Unlike Newtown and Uvalde, the members of the majority party controlling the community mental health agenda at the time of Parkland never expressed any legislative or rhetorical support for the Excellence in Mental Health and Addiction Treatment Expansion Act. This finding suggests that not a single member of leadership possessed an interest in using their agenda powers to promote the bills on the legislative agenda. Further, the lack of support may imply that leadership would have used negative agenda controls to prevent the legislation from reaching a decision point. Taken together, this absence of support provided information to politicians and policy entrepreneurs that the majority leaders would not

guarantee the gates to the floor would be open to the Excellence in Mental Health and Addiction Treatment Expansion Act after coupling, leading politicians and policy entrepreneurs to not engage in coupling after Parkland despite the similar problem, policy, and political contexts to those of Newtown and Uvalde.

Chapter 7 Conclusion

Some of the most horrific tragedies in the past 15 years transformed federal community mental health policy. On December 14, 2012, a shooter killed 26 people at Sandy Hook Elementary School in Newtown, Connecticut, and on May 22, 2022, a shooter killed 21 people at Robb Elementary School in Uvalde, Texas. These events ruptured a three decade long impasse in federal community mental health policy. In 1981, Congress converted the national community mental health centers program of the 1960s and 1970s to a block grant, severely reducing the federal financial contribution to community mental health centers and allocating most regulatory oversight to states. The 2012 Newtown shooting triggered a policymaking process that led to the adoption of a bill that reversed this 30 year legacy, and the 2022 Uvalde mass shooting resulted in a law that substantially expanded the program created after Newtown.

Each event increased the likelihood of adopting community mental health legislation by incentivizing political actors to adapt existing bills so that they became the perceived solution to the problem prioritized by each event in a process known as coupling. The Newtown and Uvalde shootings stimulated attention to the problem of mental illness allegedly causing violence to levels only paralleled by the other school mass shooting, Parkland, examined in this dissertation. Political actors hooked existing bills that had stagnated in the legislative process for years, the Excellence in Mental Health Act after Newtown and the Excellence in Mental Health and Addiction Treatment Expansion Act after Uvalde, through rhetorical and design adaptations to this perceived of this problem. Politicians newly described the bills using violence rhetoric,

suggesting that the legislation was an important part of the solution to preventing another tragedy, and policy entrepreneurs adapted the bills' designs to accommodate new political interest in the problem after the event. These modifications presented the legislation as the solution to the problem prioritized after the event, carrying the community mental health bills through the legislative process and ultimately contributing to their enactment.

As described in Chapter 1, these two policies have transformed community mental health policy. Adopted after Newtown, the Excellence in Mental Health Act created a new community mental health provider – certified community behavioral health clinics (CCBHCs) – and a Medicaid program to support establishing and sustaining CCBHCs. The Excellence in Mental Health and Addiction Treatment Expansion Act, passed after Uvalde, expanded the CCBHC program to more states and extended the program for several years. Together, these policies, as well as another CCBHC program building on top of the 2014 Excellence in Mental Health Act, have allocated nearly $3 billion to CCBHC initiatives, expanding the program from 67 clinics in eight states in 2017 to over 500 clinics operating in 46 states, Washington D.C., Puerto Rico, and Guam today.[86] Democratic and Republican lawmakers, as well as organizations representing community mental health centers at the federal and state-levels, describe these CCBHC programs as revolutionizing community mental health (Blunt 2016, 2021; Stabenow 2015, 2022b).

The Newtown and Uvalde policymaking stories may create an expectation that school mass shootings that substantially raise public and political attention to the problem of mental illness allegedly causing violence produce community mental health policy reforms. Put another

[86] The other program is called the CCBHC Expansion Grant program. Clinics who meet or will soon meet CCBHC certification criteria are eligible to receive lump sum grants to support the CCBHC model. Congress has appropriated funds to the CCBHC Expansion grant program several times but has never encoded the program's design in federal statute.

way, these crises create opportunities where legislation previously conceived as impossible becomes achievable and guarantee that these policies become law. However, a remarkably similar event in Parkland, Florida did not stimulate the adaptation or adoption of the same community mental health policy proposals as those coupled after Newtown and Uvalde, refuting the argument that school mass shootings are a sufficient condition for enacting community mental health policy.

On February 14, 2018, a shooter killed 17 individuals at Marjory Stoneman Douglas Highschool in Parkland, Florida. Like Newtown and Uvalde, Parkland heightened attention to the perceived relationship between mental illness and violence. However, despite lawmakers introducing the same policy adopted after Uvalde four months before Parkland, political actors did not couple, or adapt, the Excellence in Mental Health and Addiction Treatment Expansion Act to this problem. Indeed, politicians made no rhetorical adaptations that linked the policy with the problem of mental illness allegedly causing violence, and policy entrepreneurs did not modify the policy's design to accommodate new political interest in the problem after the shooting. Why did the Newtown and Uvalde mass shootings catalyze the adaptation of substantial community mental health legislation to align with the problem garnering attention after the event, ultimately contributing to these bills becoming laws, but Parkland had no impact on the adaptation or enactment of the same community mental health policy?

The relationship between these mass shootings and community mental health policy depends on a feature engrained in American political institutions. The three mass shootings shared much of the same problem, policy, and political context, including heightening attention to the same problem, having the same or similar community mental health bills on the legislative docket, and benefitting from bipartisan support for the policies led by the same four lawmakers.

However, Parkland differed from Newtown and Uvalde in legislative support for the community mental health bill from relevant agenda setters. The exceptional agenda controls possessed by these lawmakers made their legislative support crucial to the decision to couple community mental health policy with the problem garnering attention after Newtown, Parkland, and Uvalde. Despite facing similar incentives to align existing community mental health policies with the problem prioritized by each mass shooting, the decision to engage or pass on coupling depended on perceptions about this leadership support. Out of concern that majority leaders would use their agenda controls to prevent the adapted legislation from leaving committee and reaching the floor, politicians and policy entrepreneurs judged if lawmakers occupying these leadership positions would block or permit the bill from progressing through the legislative process.

After the Newtown and Uvalde shootings, the political actors involved in coupling received a signal implying that important agenda setters favored the community mental health legislation. Indeed, the chairs of the committees and subcommittees assigned the community mental health bills – some Democratic and some Republican – sponsored the Excellence in Mental Health Act and the Excellence in Mental Health and Addiction Treatment Expansion Act. As a result, politicians and policy entrepreneurs perceived the costs of the coupling process worth the potential public policy benefits of adaptation, leading these political actors to modify existing proposals to become the perceived solution to the problem garnering attention after each event. However, the members of the majority party controlling the community mental health agenda at the time of Parkland did not offer this support for the equivalent community mental health policy proposal. No member of Senate or House majority leadership displayed support through sponsorship or rhetoric that they would not prevent the coupled bill from progressing through the legislative process. Consequently, the political actors responsible for coupling chose

not to engage in this adaptation process, even though they faced similar incentives to the politicians and policy entrepreneurs responsible for coupling after Newtown and Uvalde.

In summary, this dissertation can be recapped in two points. First, the Newtown and Uvalde mass shootings revolutionized federal community mental health policy because political actors adapted existing policies to align with the problem prioritized by each focusing event through two processes: one related to proposal adaptation and the other to proposal design. Second, the absence or existence of policy support from agenda setters before or at the onset of coupling explains why Parkland did not catalyze this coupling process, but Newtown and Uvalde did.

What have we learned about the relationship between mass shootings and mental health policymaking? Importantly, the majority of mass shootings do not have the potential to impact mental health policy. This dissertation focused on three mass shootings – Newtown, Parkland, and Uvalde – because they prioritized the problem of mental illness allegedly causing violence. The thousands of other mass shootings between 2009 and 2022 may have increased attention to this problem but not so much so that the issue reached the apex of public and political attention. Put another way, these events do not meet my definition of a focusing event. I list many, but not nearly all, of these events in Appendix A, including the shootings at Route 91 Harvest music festival in Las Vegas, Nevada on October 2, 2017 where 58 were killed and 546 were injured; Pulse Nightclub in Orlando, Florida on June 12, 2016 where 49 were killed and 53 were injured; and First Baptist Church in Sutherland Springs, Texas on November 5, 2017 where 26 were killed and 20 were injured. For some reason, these mass shootings did not raise attention to the

problem of mental illness causing violence to the same levels as the events in Newtown, Parkland, and Uvalde.[87]

While it is not in the scope of this dissertation to answer why some but not all mass shootings prioritize the problem of mental illness allegedly causing violence, it is important to consider what this difference means for mental health policymaking. Unlike the other mass shootings during this period, Newtown, Parkland, and Uvalde created unique opportunities to enact mental health policy reforms. These focusing events heightened attention to the problem of mental illness allegedly causing violence, making it a priority issue. This surge in attention incentivized political actors to hook existing community mental health policy proposals to this problem because the link would increase the likelihood of adopting the policy. In contrast, other mass shootings do not provide this prioritized problem that political actors can use to carry a modified mental health bill through the legislative process. Thus, there is no incentive for political actors to adapt existing mental health policies and engage in the coupling process. As a result, the substantial majority of mass shootings will likely have no impact on mental health policymaking.

However, even when mass shootings prioritize the problem of mental illness allegedly causing violence, political actors do not necessarily take advantage of the incentives to adapt existing mental health policies to become the perceived solution to this issue. All crises create "an opportuntity to do things that you think you could not do before" (Emanuel 2008). Indeed, Newtown, Parkland, and Uvalde are undoubtedly examples of such crises. Each focusing event created opportunities to adopt substantial mental health policy reforms that had stagnated at the bottom of the legislative agenda for years before the mass shooting. But crises only generate

[87] See my analysis in Appendix B for determining which mass shootings focused attention on the problem of mental illness allegedly causing violence and which may have raised interest but not to the level of a focusing event.

incentives. They do not guarantee that political actors will respond to these incentives by pursuing policy activities, including those related to coupling, that increase the likelihood that a bill becomes law. I shed light on when and why political actors acted on the incentives related to mental health after a mass shooting, and when and why they decided to pass on these windows of opportunity.

The comparison between the Newtown, Parkland, and Uvalde shootings allows me to eliminate several variables that may impact the decision to adapt mental health policy to become the alleged solution to the problem garnering substantial attention after each event. These include factors related to the shooting profile, the policy design, bipartisan member policy support, legislative interest in gun control, and the party possessing the majority of seats. The answer boils down to an ingrained feature of American political institutions: the agenda setting powers afforded to a subset of members of the majority party. I find support that a mass shooting triggered the adaptation of community mental health policy when political actors judged that majority leaders would not use agenda controls to prevent a bill from climbing the legislative agenda. When individuals in these same positions perceived that leadership might use these controls to block the legislation from leaving committee and reaching the floor, they did not engage in the coupling process. Put simply, political actors adapted community mental health after a mass shooting when majority leadership signaled, rather unequivocally through sponsorship, that they supported the policy.

Notably, this finding suggests that simply possessing majority control does not explain when political actors engaged in coupling community mental health policy proposals with the problem of mental illness allegedly causing violence. The partisan distribution at the time of Newtown, Parkland, and Uvalde never provided the majority party enough seats to guarantee the

passage of these bills without bipartisan support. Indeed, when the new Congress was sworn in three weeks after Newtown, Congress was divided, requiring the legislation to survive the policymaking and negotiation process of a Republican House and a Democratic controlled non-filibuster-proof Senate. When Uvalde occurred in May 2022, Democrats held majorities in each chamber but only marginally so in the Senate. Indeed, control stood on a mere vote in a Senate with 48 Democrats, 50 Republicans, and 2 Independents that voted with the Democratic coalition. Thus, no party had sufficient seats to adopt the policy without the support of their cross-party peers.

This dissertation shows that something else related to majority control explains the difference in coupling outcome. The majority party not only benefits from more seats than the minority but also possesses agenda setting powers that provide them immense influence over which bills progress through or stagnate in the legislative process. These controls are centralized within a small number of leadership positions. The decision to pursue coupling depends on judgments about members occupying two of these leadership positions with substantial control over mental health policymaking: the committee and subcommittee chairs where mental health policies are assigned. Thus, the decision to pursue the coupling of community mental health policy after a mass shooting depends not on the party in control of the majority but on political actor assumptions about how the small group of lawmakers within the majority party possessing substantial agenda controls will apply their powers to these modified policies.

Finally, I want to address a potential assumption a reader may make about my conclusions: mass shootings are necessary for enacting mental health policy and the subset of these policies related to community mental health. Put in question form, does the American political system require a mass shooting to change mental health policy? While this dissertation

does not provide an answer, I will shed some insights on how my analysis informs this question. First, Congress has adopted several mental health policies within the past 15 years that have not been linked to mass shootings. These include the 2020 National Suicide Hotline Designation Act, which incorporated into statute the 3-digit dialing code for the National Suicide Hotline. The 2020 Crisis Stabilization and Community Reentry Act created programs to improve collaboration between the criminal legal and mental health treatment systems. Congressional discussions of these bill never mentioned the Newtown, Parkland, or Uvalde shootings, suggesting that none of the events impacted the policymaking process that led to these bills' enactment.[88]

Mass shootings also explain some but not all federal community mental health policy expansions. In 2015, Congress increased federal allocations to the Community Mental Health Services Block grant from $450,000,000 to $532,571,000, representing the most significant increase in block grant funding in 15 years. In discussions of the bill, the 21st Century Cures Act, lawmakers referenced the December 14, 2012 Newtown shooting, suggesting that lawmakers may have used this event to further the policymaking process that resulted in the bill's passage. However, my review of 555 press releases and floor remarks between 2009 and 2022 reveals that lawmakers used less violence rhetoric in 2015 than in 2013 and 2014, suggesting that while Newtown may have impacted this bill's passage, the shooting was likely not as fundamental to its policymaking process as that of the Excellence in Mental Health Act. Congress again

[88] I compiled the list of laws by gathering laws, except those related to appropriations, mentioned in blog posts by a major mental health advocacy organization – the National Council for Mental Wellbeing – between 2009 and 2022. To identify references to mass shootings, I searched the following search structure – "statute" AND "mass shooting" – in the Congressional Records search of congress.gov. For the statute component, I did not include the word "Act." For the laws passed on April 1, 2014 and December 13, 2016, I searched both the name of the standalone legislation and the name of the law it was incorporated into. The keywords used for Newtown were "Newtown" OR "Sandy Hook." The keywords used for Parkland were "Parkland" OR "Marjory." The keywords used for Uvalde were "Uvalde" OR "Robb."

substantially increased funds to the Community Mental Health Services Block in 2022, raising allocations to $857,571,000 (Consolidated Appropriations Act 2022). My analysis of political statements shows that lawmakers rarely used violence rhetoric to describe community mental health policies during this period, suggesting that mass shootings likely did not impact the process leading to this bill's enactment.

In summary, I do not believe that Congress requires a mass shooting to expand mental health policy. Several examples of federal mental health policy reforms within the past thirty years demonstrate that lawmakers pass mental health policies even when a mass shooting does not prioritize the problem of mental illness allegedly causing violence. That being said, these reforms are more likely in the wake of a mass shooting because of this problem prioritization. Newtown, Parkland, and Uvalde heightened attention to the perceived relationship between mental illness and violence, incentivizing political actors to adapt existing policies to become the apparent solution to this problem and increasing the likelihood that lawmakers would adopt these modified policies.

Appendices

Appendix A: Mass Shootings That Are Not Focusing Events

Appendix Table A.1: List of Mass Shootings That Do Not Meet My Definition of a Focusing Event

Place	Location	Date	Killed	Injured	CR				WSJ				NYT			
					M1	M2	M3	M4	M1	M2	M3	M4	M1	M2	M3	M4
Route 91 Harvest music festival	Las Vegas, NV	Oct. 2, 2017	58	546	28	20	13	13	2	1	1	0	2	7	0	1
Pulse	Orland, FL	Jun. 12, 2016	49	53	30	22	0	25	6	6	0	1	4	5	1	1
First Baptist Church	Sutherland Springs, TX	Nov. 5, 2017	26	20	20	13	13	35	1	1	0	13	7	0	1	15
Walmart	El Paso, TX	Aug. 3, 2019	22	26	2	25	19	23	5	5	0	0	5	2	2	0
Binghamton Civic Association	Binghamton, NY	Apr. 3, 2009	14	4	20	19	22	22	0	1	0	0	0	0	0	2
Fort Hood	Fort Hood, TX	Nov. 5, 2009	13	31	15	28	5	5	2	1	1	2	5	3	0	2
Century 16 movie theater	Aurora, CO	Jul. 20, 2012	12	70	6	1	5	2	5	2	0	0	1	1	0	1
Navy Yard	Washington, D.C.	Sep. 16, 2013	12	8	19	14	12	10	2	2	3	0	5	0	0	0
The Borderline Bar & Grill	Thousand Oaks CA	Nov. 7, 2018	12	22	2	22	14	19	3	0	5	0	1	2	0	4
Virginia Beach Municipal Center	Virginia Beach, VA	May 31, 2019	12	4	29	44	23	2	1	0	0	5	2	1	0	5
Tree of Life Synagogue	Pittsburgh, PA	Oct. 27, 2018	11	6	9	2	22	14	1	3	0	5	0	1	2	0

King Soopers Supermarket	Boulder, CO	Mar. 22, 2021	10	0	47	24	27	11	0	0	0	0	10	5	9	4
Santa Fe Highschool	Santa Fe, TX	May 18. 2018	10	13	20	34	19	10	0	0	0	0	2	2	2	2
Entertainment District	Dayton, OH	Aug. 4, 2019	9	27	2	25	19	23	5	5	0	0	5	2	2	0
Umpqua Community College	Roseburg, OR	Oct. 1, 2015	9	9	24	15	29	33	8	2	12	3	7	1	8	7

Note: CR – Congressional Record; WSJ – The Wall Street Journal; NYT – The New York Times. The 90th percentile for *The New York Times* was 7 articles. For *The Wall Street Journal*, it was 5 articles, and for the Congressional Record, it was 30. I identified other mass shootings from Mother Jones - https://www.motherjones.com/politics/2012/12/mass-shootings-mother-jones-full-data/.

Appendix B: Mass Shootings That Are Focusing Events vs. Other Mass Shootings

Some mass shootings meet my definition of a focusing event – events that rapidly increase public and political attention to a problem, so that the problem becomes a priority – while others may heighten attention to the problem that mental illness allegedly causes violence, but not to the point where the problem becomes a prime concern. I distinguished mass shootings that were focusing events from other events by analyzing public attention from newspaper coverage from *The New York Times* and *The Wall Street Journal* and political attention from the Congressional Record.[89] I identified mass shootings that were focusing events in the following way. First, I identified periods with high public and political attention to the problem of mental illness allegedly causing violence. I operationalized this as months when the total number of statements mentioning both mental illness and violence in the month, the preceding month, or the subsequent month was in the 90th percentile for all sources.[90] I imposed the 90th percentile requirement because my focusing event definition requires that the event raise public and political attention to priority status, not just heighten attention. Second, I identified the mass shooting(s) that triggered the increase in attention to the problem of mental illness allegedly causing violence. These mass shootings are the focusing events.

[89] I include these news sources because of their ideological leanings – *The New York Times* is a more liberal outlet, while *The Wall Steet Journal* leans more conservative – allowing me to assess whether public attention increased among Democrats, Republicans, or both.

[90] The 90th percentile for the New York Times was 7 articles. For the Wall Street Journal, it was 5 articles, and for the congressional record, it was 30.

Take the hypothetical example in Appendix Table B.1. The 90th percentile for *The New York Times* is 90 articles, *The Wall Street Journal* is 45 articles, and the Congressional Record is 60 statements. Panel A contains a period where the problem that mental illness allegedly causes violence is a priority issue. The total number of monthly statements is at or above the 90th percentile for all sources. Panel B also contains a period where the problem that mental illness allegedly causes violence is a priority problem. The total number of statements in month 1 and its preceding month, month 2, is at or above the 90th percentile for all sources. The period of increased public and political attention is month 1 and month 2. Panel C does not contain a period where the problem that mental illness allegedly causes violence is a priority issue. There is no month where that month, the preceding month, or the following month is at or above the 90th percentile for all sources.

Appendix Table B.1: Example of Calculation Process Used to Identify Months Where the Link Between Mental Illness and Violence Was a Priority Concern

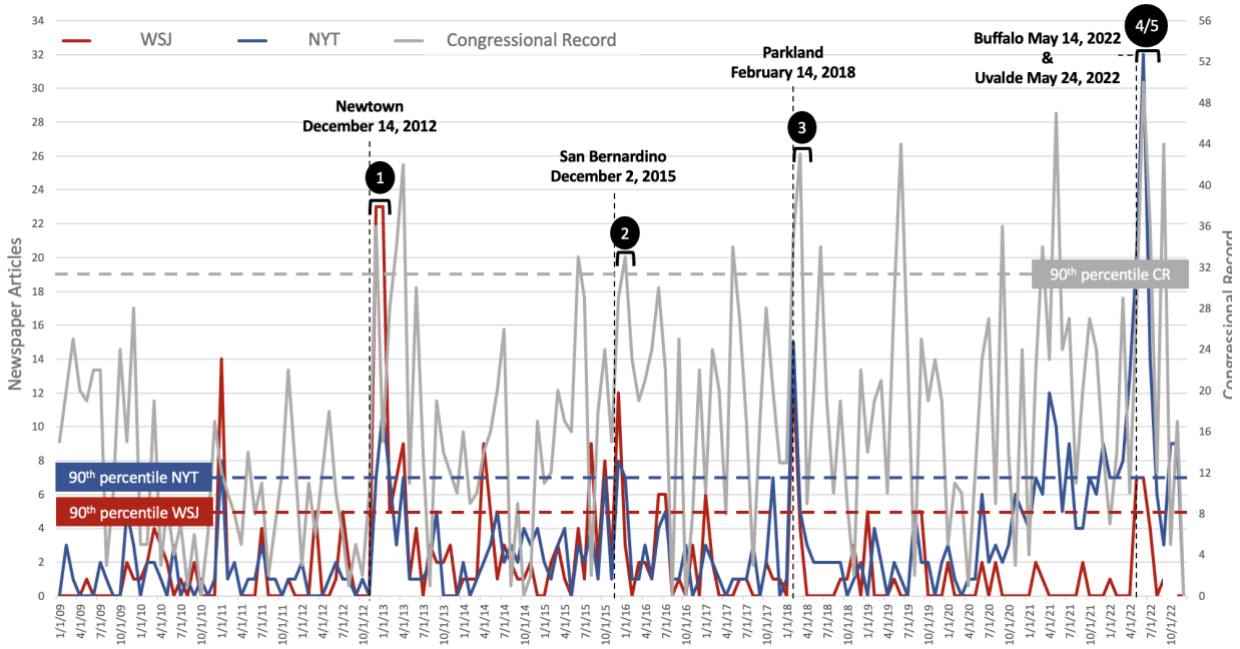
	Congressional Record (90th percentile = 60)	***The Wall Street Journal* (90th percentile = 45)**	***The New York Times* (90th percentile = 90)**
Panel A: Period **where** relationship between mental illness and violence is a priority			
Month 1	70	55	90
Panel B: Period where relationship between mental illness and violence is a priority			
Month 1	70	42	70
Month 2	55	55	90
Panel C: Period where relationship between mental illness and violence is <u>not</u> a priority			
Month 1	55	42	70
Month 2	42	39	95
Month 3	62	24	70

Note: I bold the months where the total number of statements in a month is at or above the 90th percentile for all months between January 1, 2009 – December 31, 2022.

In Appendix Figure B.1, I present my analysis, concluding that there were four periods with priority public and political attention to the problem that mental illness allegedly causes violence. These periods were December 2012 – January 2013, December 2015 – January 2016, February – March 2018, and May – July 2022. Five mass shootings were focusing events that

produced these substantial increases in public and political attention. The five tragedies occurred in Newtown, Connecticut on December 14, 2012; San Bernardino, California on December 2, 2015; Parkland, Florida on February 14, 2018; Buffalo, New York on May 14, 2022; and Uvalde, Texas on May 24, 2022.[91] Appendix Table B.2 provides the number of articles from *The New York Times* and *The Wall Street Journal* and statements in the Congressional Record released in the four months after each event.

Appendix Figure B.1: Mass Shootings That Were Focusing Events (January 1, 2009 – December 31, 2022)



Note: WSJ: *The Wall Street Journal*. NYT: *The New York Times*. CR: Congressional Record. I identified news articles using the following search strategy. In *The New York Times* and *The Wall Street Journal* Databases in ProQuest News & Current Events, I searched the following text string: ("mental illness" OR "mental health") AND ("violence" OR "violent" OR "gun" OR "shooting"). I limited the search to anywhere in the article except the full text, meaning that the search included the title, abstract, subject, and other summary. I further limited the search by excluding articles with a source type other than "Newspaper" and articles not written in English. I

[91] Many other mass shootings occurred between 2009 - 2022. While the horrific list would be too long if only one shooting were included, other mass shootings that do not meet my definition of a focusing event include those listed in Appendix A, such as the shootings at Route 91 Harvest music festival in Las Vegas, NV on October 2, 2017 where 58 were killed and 546 were injured; Pulse Nightclub in Orlando, FL on June 12, 2016 where 49 were killed and 53 were injured; and First Baptist Church in Sutherland Springs, TX on November 5, 2017 where 26 were killed and 20 were injured. It is not in the purview of this dissertation to answer why some mass shootings are focusing events and others are not. I am interested in how a focusing event leads to coupling. However, I encourage future researchers to explore this question.

identified statements in the Congressional Record by searching the same text string in the Congressional Record search of congress.gov.

Appendix Table B.2: Number of Statements Released Monthly After Focusing Event

	Month 1	**Month 2**	**Month 3**	**Month 4**
Newtown shooting, 14 December 2012				
Congressional Record	36	15	28	34
Wall Street Journal	23	23	5	7
New York Times	7	11	7	3
Parkland, 14 February 2018				
Congressional Record	35	43	9	20
Wall Street Journal	13	4	0	0
New York Times	15	5	3	2
Uvalde, 24 May 2022				
Congressional Record	28	50	36	12
Wall Street Journal	7	7	4	0
New York Times	20	32	14	6

Notes: The bolded numbers are above the 90th percentile for the total number of statements per month. The 90th percentile for the *New York Times* was 7 articles. For the *Wall Street Journal*, it was 5 articles, and for the Congressional Record, it was 30.

The perpetrator of the shooting at Sandy Hook Elementary School in Newtown, Connecticut injured two people and killed 20 children between the ages of six and seven years old and six adult staff members. The horrific incident remains the deadliest mass shooting at an elementary school in US history. The San Bernardino shooters murdered 14 people and 22 others at the Inland Regional Center, which provides services for persons with developmental disabilities. The Parkland murderer killed 17 people and injured 17 others at Marjory Stoneman Douglas High School, located in a suburb of Miami. The tragedy surpassed the Columbine High School massacre that killed 15 on April 20, 1999 as the deadliest mass shooting at a high school in United States' history. The final focusing event involves two shootings that occurred within 10 days of each other. On May 14, 2022, a shooter killed 10 people and injured three in a predominately Black neighborhood in Buffalo, New York. Ten days later, the perpetrator of the

shooting at Robb Elementary School in Uvalde, Texas fatally shot 19 students and two teachers and injured 17 others.

In summary, the analysis of the Congressional Record, *The New York Times*, and *The Wall Street Journal* demonstrates that five mass shootings created four focusing events. Each event abruptly increased public and political attention to the problem of the alleged link between mental illness and violence, so much so that it became a priority problem. The shootings in Newtown, San Bernardino, and Parkland were the sole mass shooting responsible for increased public and political attention. The shootings in Buffalo and Uvalde occurred within 10 days of each other and, consequently, may both be responsible for the increased attention to the perceived relationship between mental illness and violence from May to July 2022.

Appendix C: Methodological Approach for Content Analysis

In this section, I discuss my methodological approach to identify changes over time in violence rhetoric of community mental health policy proposals in press releases and floor remarks. Specifically, my approach uses a qualitative content analyses to identify the evolution of violence descriptions.

Search Strategy - Congressional Record

I collected the universe of floor remarks in the House and Senate that mentioned community mental or behavioral health from January 1, 2009 and July 31, 2022. I conducted this search in the "Legislation" function of congress.gov, selecting the options "include full text when available" and "word variants." I searched the following keywords: "community mental," "community behavioral," "community-based behavioral," "community based behavioral," "community-based mental," and "community based mental."

Press release search strategy

My search strategy aimed to collect press releases that discuss community mental health issued between January 1, 2009 and July 31, 2022 by senators in office on July 1, 2022. There are two important limitations of this dataset. First, my approach inherently excludes press releases by senators in office during the 12-year study period but not serving in the 117th Congress. This constraint results from the location of my search: .gov websites. Formerly serving public officials do not maintain their .gov website upon leaving their position, so I cannot access press releases from senators not actively in public office. This limitation resulted in the exclusion

of 75 of the 175 senators who served at any time between 2009-2022.[92] Consequently, I likely gather only a sample of the press releases issued in earlier years because I cannot access statements from senators not serving on July 1, 2022.

Appendix Table C.1 presents the number of senators in my sample by Congress. Put another way, it contains the number of senators for each Congress who remained in office on July 1, 2022. For instance, of the 100 senators in office during the 111th Congress, my dataset contains the 39 still in office on July 1, 2022. The proportion of senators in office who are in my sample increases over time. Indeed, 12 senators whose first term was the 112th Congress are in my sample, bringing the total number of senators in my sample for this Congress to 51 (39 from the 111th Congress plus the 12 new senators from the 112th). My sample contains 39.0% of senators in office in the 111th Congress, 51.0% in the 112th Congress, 63.0% of the senators in office during the 113th Congress, 74.0% of the 114th Congress, 80.0% of the 115th Congress, 91.0% of the 116th Congress, and 100.0% of the 117th Congress.

Appendix Table C.1: Number of Senators "In Sample" for Each Congress

Congress	Years	New senators in sample	Total senators in sample
111	2010	39	39
112	2011-2012	12	51
113	2013-2014	12	63
114	2015-2016	11	74
115	2017-2018	6	80
116	2019-2020	11	91
117	2021-2022	9	100

The concern with this limitation is that senators in Congress on July 1, 2022 may differ in ways relevant to violence rhetoric related to community mental health policy proposals than those who left Congress during the study period. I address this limitation in two ways. First, I

[92] I gather data on senators in Congress between 2010-2022, including the data producing the analyses presented in Tables C.1 and C.2, from https://history.house.gov/Institution/. I define a senator's party as her party affiliation when leaving office.

compare the data from press releases and floor remarks. Since my dataset contains the universe of floor remarks mentioning community mental health between 2010-2022, if the proportion of press releases that contain the four descriptions resemble that of the floor remarks, I assume that the press release data produce accurate prevalence rates.

In Figures 3.1 and 3.2 of Chapter 3, I presented the proportion of statements and descriptions that contain violence descriptions. The Figures demonstrate that the trends follow a similar distribution for floor remarks and press releases. In sum, the proportion of statements and references containing violence characterizations peaks in 2012/2013 and 2022 with dips in between.

Second, I compare the proportion of Democratic and Republican senators in my sample to the party distribution among the population of senators in office for each Congress. I assume that the number and content of press releases will be more similar within parties than across parties. Thus, if the proportion of senators in Congress shares a similar party distribution to those in my sample, my dataset should accurately depict the prevalence of descriptions in press releases overall and by party.

See Appendix Table C.2 for this comparison. I present statistics for three groups: (1) in sample – senators in office for the Congress in column A who remain in office on July 1, 2022, (2) in office - senators in office for the Congress in column A regardless of when he or she left office, and (3) left office – senators in office for the Congress in column A who did not remain in office for the following Congress. Thus, the table allows me to compare the proportion of Democratic and Republican senators in my sample to those who served in each Congress and to those who left office following a given Congress.

Appendix Table C.2: Proportion of Senators "In Sample," "In Office," and "Left Office" Groups

A. Congress	B. Group	C. Total	D. Democrat	E. Republican
111th	In sample	39 (100.0%)	24 (61.5%)	14 (35.89%)
	In office	100 (100.0%)	57 (57.0%)	42 (42.0%)
	Left office	16 (100.0%)	8 (50.0%)	8 (50.0%)
112th	In sample	51 (100.0%)	26 (51.0%)	24 (47.06%)
	In office	100 (100.0%)	52 (52.0%)	47 (47.0%)
	Left office	16 (100.0%)	10 (63.0%)	6 (38.0%)
113th	In sample	63 (100.0%)	34 (54.0%)	27 (42. 9%)
	In office	100 (100.0%)	53 (53.0%)	45 (45.0%)
	Left office	13 (100.0%)	10 (76.9%)	3 (23.1%)
114th	In sample	74 (100.0%)	36 (48. 7%)	36 (48. 7%)
	In office	100 (100.0%)	45 (45.0%)	53 (53.0%)
	Left office	8 (100.0%)	3 (37.5%)	5 (62.5%)
115th	In sample	80 (100.0%)	40 (50%)	38 (47.5%)
	In office	100 (100.0%)	47 (47.0%)	51 (51.0%)
	Left office	13 (100.0%)	5 (38.5%)	8 (61.5%)
116th	In sample	91 (100.0%)	43 (47.3%)	45 (49.5%)
	In office	100 (100.0%)	46 (46.0%)	51 (51.0%)
	Left office	9 (100.0%)	3 (33.3%)	6 (66.7%)

Note: I do not present statistics for the 117th Congress because my dataset contains 100.0% of senators who served during this Congress.

For most periods, the in sample partisan distribution does not resemble that of the left office group. Indeed, in comparison to the left office population, Democrats are overrepresented in my sample for the 111th, 114th, 115th, and 116th Congress, and Republicans are disproportionately represented in the 112th and 113th Congress. However, and more importantly, the table reveals that, for each Congress, the prevalence of Democratic and Republican senators in my sample resembles the proportion of Democrats and Republicans in the in office group. Thus, the party make up in my sample does not differ substantially from the Senate partisan distribution for each Congress. Therefore, if my assumption holds that Democratic and Republican senators use descriptions in ways like their party peers, my sample should reflect the prevalence of topics throughout my study period.

Second, in July 2022, I searched the following keywords in the search function of each senator's .gov website: "community mental health," "certified community behavioral health clinic," "CCBHC," "federally qualified behavioral health clinic," and "federally-qualified community behavioral health center."[93] In April 2023, I added the following keywords: "community behavioral," "community-based mental," and "community-based behavioral." This resulted in the addition of 83 press releases to the 350 identified in July 2022. The problem with this addition is that the 118th Congress was sworn in on January 3, 2023. Thus, I could not identify press releases associated with these keywords and not the original ones from senators who served in the 117th but not the 118th Congress because their .gov websites were no longer available. This applies to 8 senators: Blunt, Burr, Inhofe, Leafy, Portman, Sasse, Shelby, and Toomey.

I am not concerned that excluding their results biases my analysis. First, the April 2023 search revealed 10 senators who only had relevant press releases gathered from the April 2023 search and no press releases from the July 2022 search. Eight of these senators were Democrats. Since the five senators excluded from the April 1 search that did not already have a press release were all Republican (i.e., senators Burr, Inhofe, Sasse, Shelby, and Toomey), it is unlikely that I would have identified any new press releases issued by these lawmakers. Further, analyses included in Appendix D reveal that the prevalence of descriptions is similar in press releases gathered through the July 2022 and April 2023 search. This demonstrates that even if I identified

[93] The search function on Senator Jim Inhofe's website, https://www.inhofe.senate.gov/, was and remained broken from July 2022 until he left office in January 2023.

new press releases, it is unlikely that the prevalence of frames would differ from the current estimates.[94]

Inclusion Criteria

I include floor remarks and press releases in the analysis that discuss community mental health in the main text body. I operationalize this inclusion criteria through the presence of a specific phrase that explicitly or implicitly implies community mental clinics, care, or policy. Examples of these phrases include "community mental health," "community mental health care," "community behavioral health," "community behavioral health care," "community mental health clinic," or "community behavioral health clinic." I also include statements with phrases referencing the certified community behavioral health clinic (CCBHC) model or program. CCBHCs are a type of community mental health provider that must fulfill federal and/or state requirements related to care access, quality, and coordination. Examples of CCBHC language include references to the current - "certified community behavioral health clinic" or "CCBHC" – or previous - "federally qualified behavioral health clinic" or "federally-qualified community behavioral health center" – model names. I also include statements containing the phrase, "community behavioral health center model," which is an unofficial name used to refer to CCBHCs. In addition, I include documents that reference the two federal policies that contain content exclusively related to CCBHCs: the "Excellence in Mental Health Act" and the "Excellence in Mental Health and Addiction Treatment Act."[95] I also include statements that reference the two federal CCBHC programs: Section 223 Medicaid Demonstration and

[94] I also note that the search function on senators Barasso, Blackburn, and Stabenow's .gov websites were not working as of April 19, 2023. I frequently check these senators' websites in the hopes of including their press releases in the analysis.

[95] While Congress enacted the CCBHC model in 2014 as a provision of the Protecting Access to Medicare Act, the CCBHC component was first introduced as standalone legislation titled "The Excellence in Mental Health Act." Subsequent standalone CCBHC legislation was titled "The Excellence in Mental Health and Addiction Treatment Act."

SAMHSA Expansion Grant program. I gather press releases mentioning the Section 223 Medicaid Demonstration program through phrases like "community mental health services demonstration project," "Section 223 Demonstration," and "demonstration program to improve community mental health services." References to the SAMHSA Expansion Grant program occurred explicitly through the following phrases: "Expansion Grant" or "SAMHSA grant program."

I apply additional inclusion criteria to the press release data. Specifically, I exclude documents where the only reference to community mental health is in a re-print of a senator's floor remark or letter. I also exclude press releases that only implicitly reference community mental health through references to a policy that contains a community mental health provision, among many other provisions (e.g., the CARES Act, the American Rescue Plan). Further, I exclude press releases where the sole mention of community mental is embedded within an organization's name, and that reference exists in a long list of supporters of the proposal.

I also exclude items from the Congressional Record data. Specifically, I only include floor remarks that discuss a law or a provision of law creating or modifying a program exclusively related to community mental health (e.g., grant program), the federal community mental health centers program, or a local community mental health center. I exclude remarks where the only reference to community mental health exists in a title or other proper noun.

Coding

I operationalize the descriptions as topics identified through a qualitative content analysis. Like other researchers, I argue that topics are an ideal tool for identifying descriptions because they bring attention to a sub-set of the many concepts that may be present in a discussion. I identify these topics through a content analysis, which intends to locate the presence

of and interactions between words and themes in text data (Elkins, Spitzer, and Tallberg 2018; Elo et al. 2014; Hsieh and Shannon 2005). While some of the previous literature taking this approach quantitatively identifies frames through structural topic models (Gilardi, Shipan, and Wüest 2021), my approach resembles Baumgartner et al.'s (2008) qualitative frequency analysis of newspaper abstracts related to the death penalty in which the authors count the number of newspapers articles using a particular argument at a given time. While the search strategy and inclusion criteria differ between the press release and the Congressional Record data, the coding and analytical approach is consistent.

In line with the conventional approach to content analysis, I developed the coding scheme a priori and then revised it iteratively during a review of 10 percent of included press releases (Hsieh and Shannon 2005). An undergraduate student at the University of Michigan and I coded each of the 469 floor remarks and press releases identified from the July 2022 search independently. We met weekly to discuss discrepancies in coding until consensus was reached. I was the exclusive coder of the 81 relevant press releases newly included after the April 2023 search.[96]

I conducted coding at the sentence level, meaning that a description existed in a sentence if that sentence referenced the description explicitly or implicitly given the content of the surrounding paragraph. I elected not to code characterizations embedded in proper nouns (e.g., Substance Abuse and Mental Health Services Administration, Department of Mental Health). Unlike other topics, senators do not elect to bring attention to characterizations implied by proper nouns. I also did not code the section of a press release that contained copied letters in their entirety. All these press releases contain introductory sections that summarize the content of the

[96] I look forward to working with another coder to confirm the coding analysis of this data.

letters. While I code these sections, I do not code the letter for two reasons. First, the letters are lengthy, making the completion of the manual content analysis infeasible. Second, the summaries contain the descriptions within the letter lawmakers hope to emphasize. Thus, by coding the introductory sections, I still capture rhetoric without having to code the entire letter. Included press releases and floor remarks were imported and coded in Nvivo 1.7.1.

Analysis

My analytical goal is to identify trends in violence descriptions of community mental health policy proposals. Consequently, I present the majority of analyses as prevalence rates. Specifically, I will provide the proportion of statements and the percent of descriptions that contain a violence description.[97,98] The denominator for the proportion of descriptions measure is the sum of all proposal descriptions in the document. For instance, a floor remark contains 10 sentences with community mental health proposal descriptions. Five of these are mental illness, three are behavioral health, two are substance use, and 10 are violence. The proportion of descriptions that are violence is 50.0%.

I examine the significance of changes in policy proposal rhetoric using χ^2 tests and t-tests. Specifically, I performed χ^2 tests of independence to compare the proportion of statements containing a violence description in year 1 to those in year 2, examining the null hypothesis that

[97] I present proportions instead of numbers (e.g., the number of statements or sentences containing descriptions) for two reasons. First, I acknowledge that my decision only to include press releases issued by senators in office on July 1, 2022 implies that I may miss relevant press releases from senators excluded from the analysis. Thus, I cannot know whether my data reflect the number of frames present in statements. However, since my sample of senators issuing press releases for each Congress shares the same partisan distribution as that Congress, and the prevalence rates for each description in the press release data resemble that of the floor remarks (see the results section), I am confident that the proportions are accurate. Second, other health politics research relies on proportions as the primary statistic in presenting descriptions (Barry et al. 2011, 200; Kennedy-Hendricks et al. 2019). Thus, my approach follows convention in showing results as the proportion of statements that mention a description.

[98] I present measures at the statement and reference levels to compare the prevalence of statements that contain a topic with the amount of text devoted to a specific issue. While the measure at the statement level conveys the proportion of statements that bring attention to a topic, it is a rather blunt measure of the amount of attention afforded to that description. The reference level measure, on the other hand, provides more granular insight on whether a description appears frequently or sporadically.

year has no association with the topic as a proportion of statements, or p(year 1) = p(year2). If the number of statements in a year is less than 10, I applied the Fisher's exact test as a substitute for the χ^2 test of independence because it is better suited to small sample sizes (Kim 2017). For the proportion of descriptions, I used independent t-tests. I tested the null hypothesis that the mean difference in the proportion of descriptions that are violence between years is zero. All tests are two-tailed with significance determined at 0.05 level.[99]

[99] I do not report these statistics for 2010, 2011, 2012 given that only two press releases were issued in 2010, and senators released zero press releases in 2011 or 2012.

Appendix D: Comparison Between July 2022 and April 2023 Press Release Collection

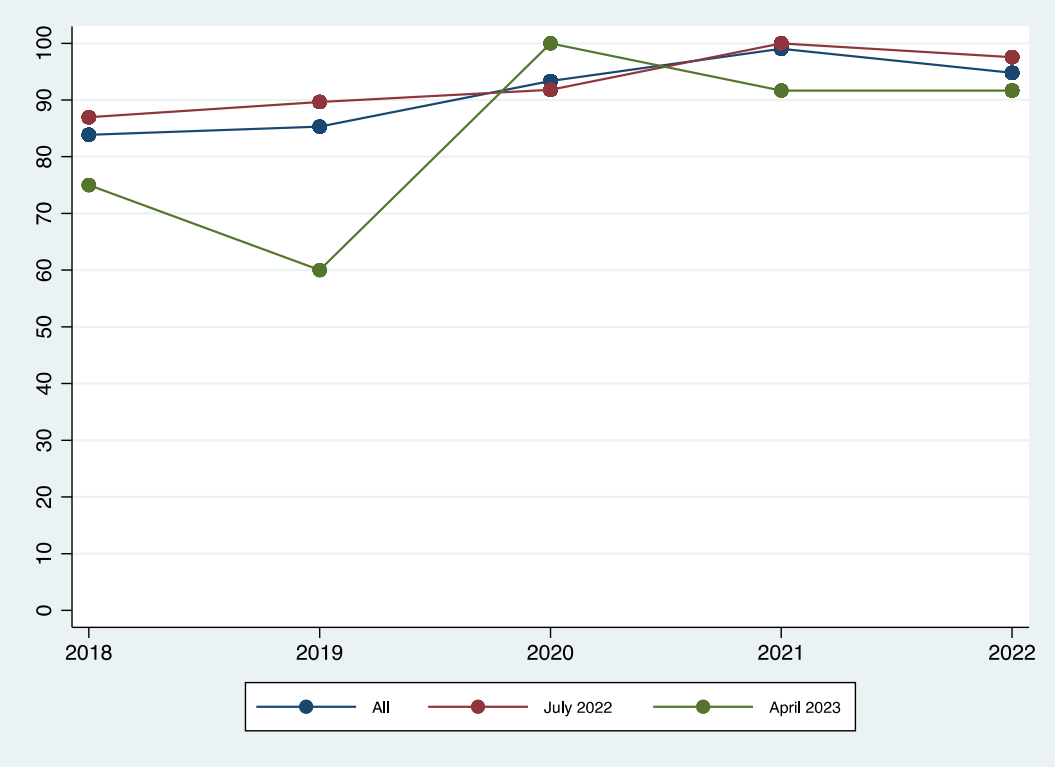
In this section, I compare the proportion of statements that contain a characterization among press releases gathered through the July 2022 and those collected in the April 2023 search. If the proportions for each characterization between the two samples are similar, I assume that the April 2023 data reflects the actual distribution of topics in press releases, despite not including the 8 senators who served in the 117th but not the 118th Congress. In Appendix Table D.1, I present the number and proportion of press releases by year and date of collection. Given that only 2.0% of press releases gathered in April 2023 were issued before 2018, I compare topic prevalence between 2018-2022.

Appendix Table D.1: Number and Percent of Press Releases by Date of Collection

Year	July 2022		April 2023	
	N	%	N	%
2010	1	0.29%	1	0.29%
2011	0	0.00%	0	0.00%
2012	0	0.00%	0	0.00%
2013	18	5.14%	0	0.00%
2014	16	4.57%	0	0.00%
2015	34	9.71%	2	0.57%
2016	17	4.86%	2	0.57%
2017	18	5.14%	2	0.57%
2018	23	6.57%	8	2.29%
2019	29	8.29%	5	1.43%
2020	61	17.43%	14	4.00%
2021	92	26.29%	12	3.43%
2022	41	11.71%	36	10.29%
Total	350	100.00%	82	23.43%

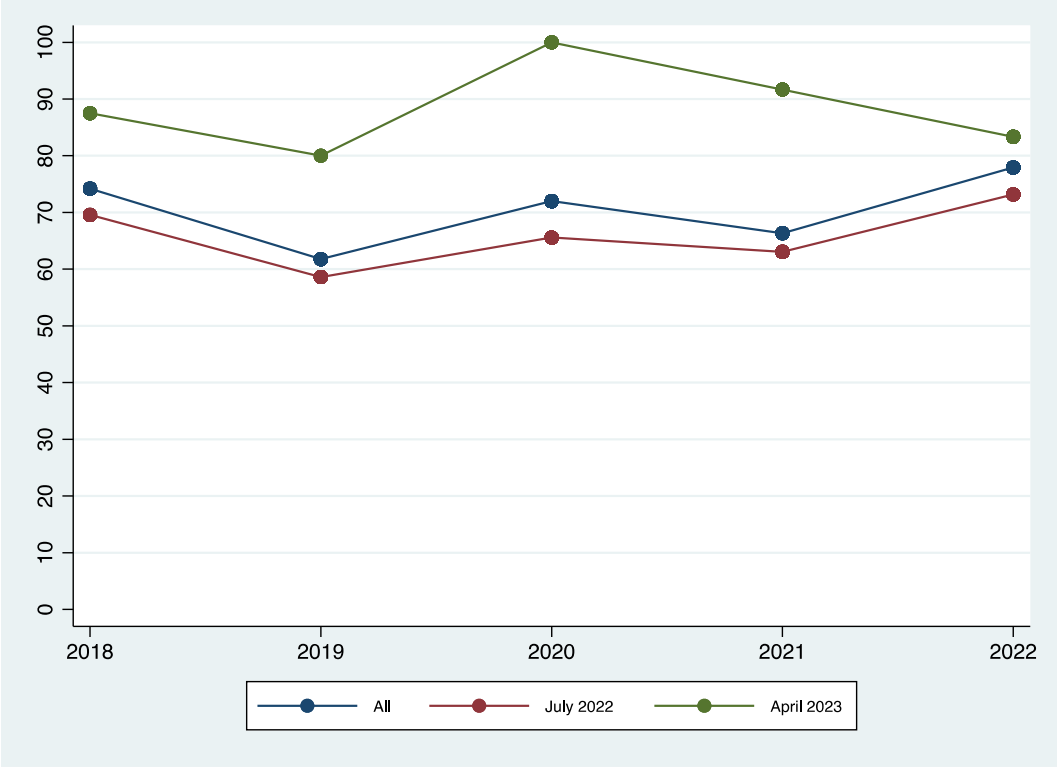
Appendix Figure D.1 demonstrates that the proportion of statements containing any mental health reference was consistent across samples. While the increase in the percent is greater between 2019 (July: 89.7%; August: 60.0%) and 2020 (July: 92.8%; August: 100.0%) for press releases gathered in April 2023 than those collected in July 2022, both increases were insignificant (July: p=0.71; August: p=0.06).

Appendix Figure D.1: Mental Health as a Proportion of All Statements



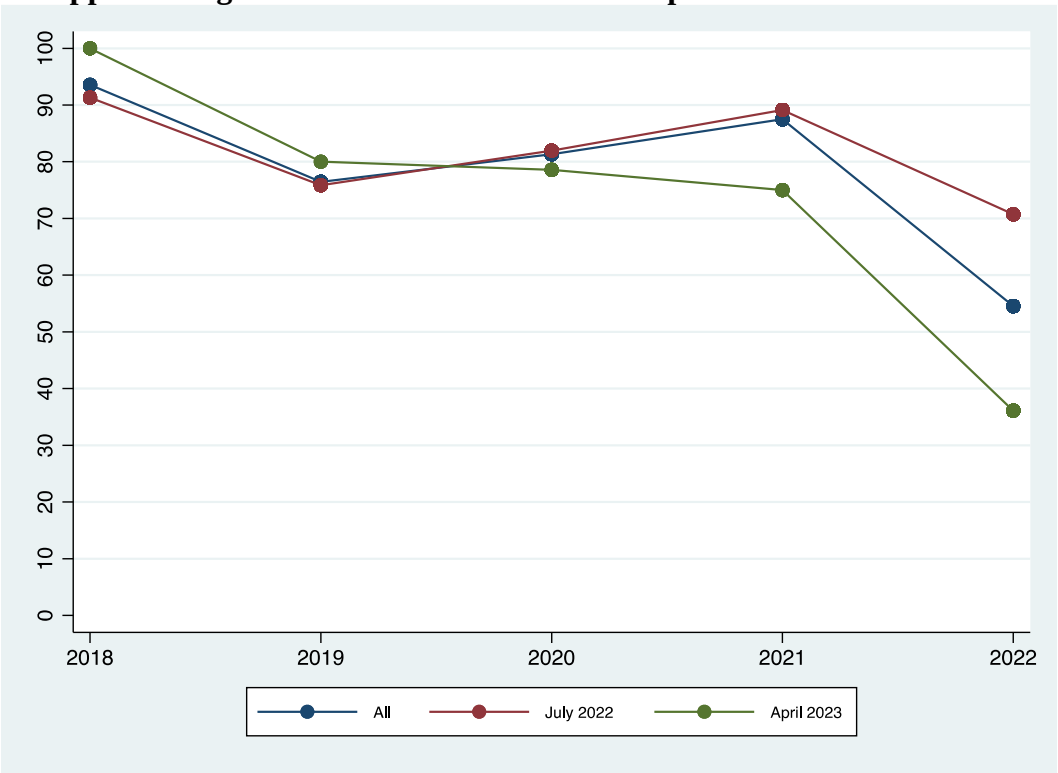
While a greater proportion of statements collected in April 2023 contained any reference to behavioral health than those gathered in July 2022 (see Appendix Figure D.2), the evolution over time was consistent. Indeed, the proportion of statements referencing behavioral health remained stable between 2018-2022 for statements gathered on July 2022 and April 2023.

Appendix Figure D.2: Behavioral Health as a Proportion of All Statements



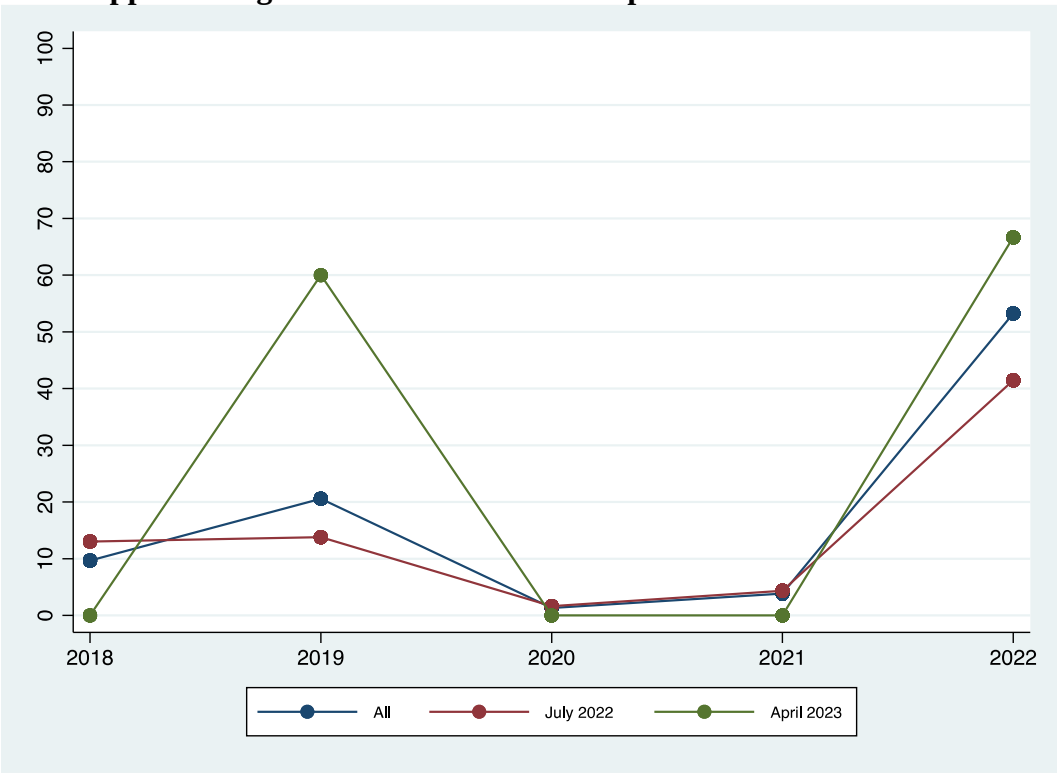
Again, I observe that substance use as a percent of statements followed a similar distribution across press releases stratified by the date of collection. In Appendix Figure D.3, I present substance use as a proportion of statements issued in a year. Indeed, the proportion of statements with any reference to substance use remained consistent until a decrease between 2021 and 2022 for statements gathered in July 2022 (2021: 89.1; 2022: 70.3%; p=0.01) and those gathered in April 2023 (2021: 75.0%; 2022: 36.1%; p=0.04).

Appendix Figure D.3: Substance Use as a Proportion of All Statements



Finally, I display the proportion of statements that contain any reference to violence in Appendix Figure D.4. The increase in the proportion between 2021 - 2022 existed for press releases collected in July 2022 (2021: 4.35%; 2022: 41.5%; $p<0.01$) and August 2023 (2021: 0.0%; 2022: 66.7%; $p<0.01$). However, the April 2023 press releases also experienced another increase from 0.0% in 2018 to 60.0% in 2019 ($p=0.03$) followed by a sharp decline to 0.0% in 2020 ($p=0.01$). The corresponding pattern in the July 2022 data is insignificant.

Appendix Figure D.4: Violence as a Proportion of All Statements



Appendix E: Rhetoric Used to Describe Community Mental Health Policy Proposals

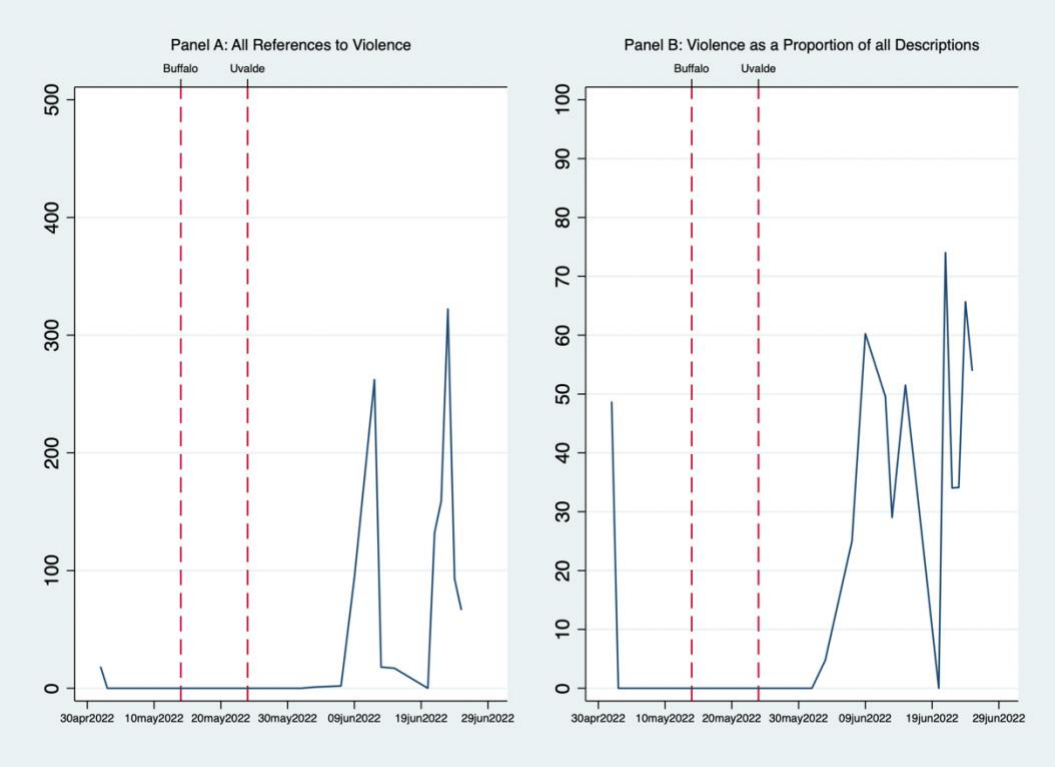
Appendix Table E.1: Four Topics Used to Describe Community Mental Health

Definition	Example
Mental Health	
Mental health, mental illness, or the mental health care system inclusive of general references, discussions of specific or serious mental disorders, and suicide or other crisis events.	"At least 25% of returning troops from Iraq and Afghanistan will experience a mental health condition."
	"Many people are struggling with depression, anxiety, and other mental health challenges as the result of a pandemic that has brought disruption, isolation, and stress."
	"There has been a double digit increase in the number of people reporting symptoms of anxiety and depression."
	"Research has shown that our current system is too fragmented and fails mental health patients, especially the seriously mentally ill, whose life expectancy is 24 years lower than the average American."
	"$10 million for National Suicide Prevention Lifeline program to support a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week."
	"2020 also saw a nearly 20% increase in the number of children calling a state-wide mental health crisis hotline."
Substance Use	
Substance use or the substance use disorder care system inclusive of general references, discussions of specific substances, and overdose or other crisis events.	"Many of the kids in foster care are there because of substance abuse at home," Senator Grassley said."
	"Congresswoman Matsui of California and I have been working on drafting a bill to increase access to substance use treatment through the use of tele-health in community mental health centers."
	"Our country has made serious in-roads in our battle against the opioid epidemic."
	"Funding will aim to curb the increase in psychostimulant misuse and overdose related deaths."
	"According to preliminary data from the U.S. Centers for Disease Control and Prevention (CDC), there were 90,000 overdose deaths for the 12 months ending last September."
	"Schumer added that Helio's CCBHC designation has played a major role in combatting the opioid epidemic and reducing overdose deaths locally."
Behavioral Health	
Behavioral health or the	"In reassessing what we have learned during COVID-19 about the secondary health effects of this pandemic, it is clear Congress must take

behavioral health care system.	steps now to ensure our country is better prepared to identify and respond to the behavioral health needs of all Americans in all times of need."
	"All of Oregon can look forward to seeing real gains from this comprehensive approach that blends behavioral health care with physical health care."
Violence	
Behaviors or events in which an individual harmed or may harm another individual. This includes references to gun violence, mass shootings, and violence prevention activities, such as red flag laws, background checks, and mental health programs explicitly linked to violence prevention.	"Today, we are announcing a commonsense, bipartisan proposal to protect America's children, keep our schools safe, and reduce the threat of violence across our country."
	"Through recent acts of violence, we have seen the tragic cost that can come from untreated mental illnesses."
	"We also must educate and empower members of the community to share information and intervene before someone does something that tragically impacts their lives and the lives of others."
	"Gun violence touches every corner of our society, from schools to places of worship to grocery stores."
	"More importantly, this could play a role in preventing future tragedies like the one we saw in Newtown last month and that is a move that our entire country should be ready to rally around."
	"'Expanding background checks for those under 21, real investment in mental health, progress on red flag laws, and closing the boyfriend loophole are all important reforms with broad, bipartisan support,' said Brown."
	"Provides resources to states and tribes to create and administer laws that help ensure deadly weapons are kept out of the hands of individuals whom a court has determined to be a significant danger to themselves or others, consistent with state and federal due process and constitutional protections."
	"The provision also encourages referrals to essential mental health resources where community behavioral health professionals can provide critical services in the aftermath of a tragedy."

Appendix F: Violence Descriptions Before and After the May 2022 Buffalo and Uvalde Shootings

Appendix Figure F.1: Violence Descriptions Before and After May 2022 Buffalo and Uvalde Shootings



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