January 2012

Unlocking the Black Box of Policymaking: A Discursive View of the Florida Commission on Mental Health and Substance Abuse

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by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy
Department of Communication
College of Arts and Sciences
University of South Florida

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Date of Approval:
October 12, 2012

Keywords: Discourse analysis, communication genres, social construction of expert and evidence, textual agency, policy analysis

DEDICATION

I would like to dedicate this dissertation to my grandparents, who instilled a love of education and a passion for knowledge into their daughter, to my mother, who instilled those same traits in her daughters, to my sister Denise, who shares these traits with me, to my children, Rhiannon and Elias, and to my grandson Caleb, who continue this familial passion with their own unique quests for knowledge.

I thank my advisor Dr. Bartesaghi for her unflagging support, ruthless critiques, and infectious delight in the pursuit of a good analysis. I also thank my committee members for their faith, efforts, and time invested in me. I thank my many "partners in crime" for their perseverative but loving reminders that I should be writing.

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ABSTRACT

Discourse creates the *world of policy*. Discourse plays a key role within policy formation; political discourse is *made visible* within particular discursive (spoken and written) practices. Hence, mental health policy is the endpoint of a discursive process and that it is, in itself, an institutional process. The shared understanding necessary to formulate policy is crucial to persons who are responsible for policy decisions and recommendations. Since the public perception is that public policy problems are too complicated for ordinary people to deal with, the policy problem is reframed into manageable "bits." It is how these "bits" are framed, named, and made sense of that concern me most in the policymaking process. The purpose of this dissertation is to make visible the often invisible processes that occur in the creation of that final report. To do so, I use a discursive approach and a selection of discourse tokens, both talk and text, to examine the workings of the Florida Commission on Mental Health and Substance Abuse.

INTRODUCTION: MAKING VISIBLE THE INVISIBLE

In public policymaking, a final report, or accounting of the work of a policy group, is often the only document the public sees. As the public, we are not involved in the spoken or written discourse exchanges that are essential to the process of public policymaking. We do not intervene in the talk. We do not read the meeting notes. We are not positioned in the midst of the myriad negotiations of the group, as the members struggle to create a single, unified voice fit for a text. The purpose of this dissertation is to make visible the often-invisible processes that occur in the creation of that final report. To do so, I use a discursive approach and a selection of discourse tokens, both talk and text, to examine the workings of the Florida Commission on Mental Health and Substance Abuse.

In the data excerpt below, I offer the reader an example of the discursive approach I will use in the dissertation. I show how Mary and Bob attempt to create a shared understanding on the use of the phrase "continuum of care."

Data Excerpt 1.1.

Exchange between Mary and Bob

1	Mary:	What does the word continuum mean to a client?
2		what does the word continuum mean to them? if you
3		talk about prevention and treatment services they understand
4		if you take out something let's take out continuum it's an
5		academic word for us we understand it [but I'm not sure
6	Bob:	[Take out what word?
7	Mary:	continuum of care use prevention and treatment
8	Bob:	no I don't think so

9 Mary: Well, if prevention and treatment are a part of the continuum is
10 this a statement for us? is it meant to guide us? but we want
11 but I think the clients understand what we're trying to do as
12 well. I don't think they relate to the word continuum
13 Bob: But that's that's limiting. If you use prevention you've ruined it
14 cause you have to put in after-care, you have to put in a lot of
15 other aspects because continuum is actually all encompassing.

Mary is concerned with the phrase "continuum of care." She wants someone to explain what that phrase means to a client (a person who utilizes mental health services). Mary notes, "continuum of care" is an academic phrase that she and Bob "understand" (lines 4-5). She is hesitant to claim that this is the correct phrase to use; she is "not sure" (line 5). However, as she states her uncertainty, Bob overlaps (speaks over) her with a question, "take out what word?" (line 6). Bob has performed a face-threatening act (Goffman, 1959; Brown & Levinson, 1987). It is an attempt to determine what Mary is talking about but it also queries the validity of Mary's claim. However, Mary does not cede the discursive floor to Bob. She carefully continues to press her point; she is trying to preserve her face and Bob's face.

When Mary tries to substitute the phrase "prevention and treatment" (line 7), she is immediately "shut down" by Bob, who attempts several discursive strategies in his face attacks. Not only does he not agree with her, he belittles her understanding. In addition, he attempts to blame/shame her into agreeing with him. Notice how Bob argues Mary is wrong: "no I don't think so" (line 8), "that's limiting" (line 13), and "you've ruined it" (lines 13-14).

Although Bob states that "continuum" encompasses all the options in the delivery of care, Mary is not satisfied. Mary wants the language to show that they (she and Bob) have a shared understanding of services with their clients and to encourage client

understanding and buy-in. In Data Excerpt 1.2, Mary emphasizes this discussion is not about her; it is about the clients. She wants reassurance that clients do understand this term (line 18). Mary positions herself as an advocate for the client in lines 18 and 19, reminding Bob, "We're for the people. We're where the clients will go."

Data Excerpt 1.2.

Closing Exchange between Mary and Bob

16	Bob:	This is just our vision statement. then we're gonna get into what
17		could we, how do we (.) going do it
18	Mary:	As long as it's somewhere clear for the client
19		We're for the people. We're where the clients will go.
20		If we're going to spend time on that later on then that will be fine
21		But just to leave it as continuum of care, I don't I don't think
22		people relate to that academic term.

However, Bob clearly wants to move on as shown in lines 16 and 17, as he states this conversation could resume later. Mary, however, is not content to let this token promise be the end of the conversation (line 21). For Mary, it is critical that the client voice is heard *and* acknowledged. For their work to move forward, both she and Bob must be clear on what the client understands to be the "continuum of care." Mary clearly implies there will be future conversations, "If we're going to spend time on that later on then that will be fine" (line 20). This discursive move also allows Bob to disengage gracefully from the conversation, retaining face on both sides. However, she has not given up on her primary claim: the goal that clients receive necessary services in a language shared by both the client and the provider.

In the two brief data analyses above, we see how two persons worked through a difficult passage determining how well a phrase, used extensively by mental health professionals, is (or is not) understood by the recipients of such services, the clients. A

phrase, such as "continuum of care," is polysemic. Because of their differences in how the term is used, Mary and Bob must now negotiate the consequentiality of the phrase.

Since talk is a situated interactional event between participants, the consequentiality of the communication between Mary and Bob must be placed in context. What if Mary and Bob are not just two mental health professionals discussing services? What if they are two members of a state commission, created by a specific piece of state legislation, to examine the delivery of mental health services within the state? Now, the interaction is more than a simple difference in semantics among professionals and the stakes are much higher.

Sigman (1995, p. 3) reminds us of the "consequentiality of communication"; *what* persons do during social interactions has an impact on their lives, the institutions in which they work or use, and the relationships they establish. The consequentiality of communication resides in "the ebb and flow of the communication process" (Sigman, 1995, p. 3), where individuals engage in continuous negotiation and renegotiation of the production of meaning and shared understandings. Consequentiality of communication differs from a communication effect. Consequentiality of communication examines the larger process of communication; a communication effect examines a small slice of the process. Hence, consequentiality requires a consideration of the "procedures, dynamics, and structures of communication," not necessarily just of the end results (Sigman, 1995, p. 3).

Consequentiality of communication has material and political-legal consequences in health services. Consider the numerous professional and institutional discourses used in the provision of care. These discourses include representations of how things were, of

how things are, and how things may, or could, or should be. Representation also refers to how language is used in text or talk to assign meaning to groups and their activities (Fairclough, 1989; Mehan, 1983, 1996). Modes of representation vary, depending on the perspective from which they are constructed (Mehan, 1983). People are represented by "populations" and services for populations are defined by polysemic terms (e.g., mentally ill, continuum of care). Since linguistic representations determine the way in which we think about people and situations, determining the appropriate, correct, or preferred representation of an individual or a group becomes significant. The politics of representation can be persuasive, resulting in situations where "decisions are presented, not discussed; credentialled, not negotiated" (Mehan, 1983, p. 188).

Setting the meaning of a term or phrase is a critical communicative move in the provision of services in public sector health care, from a provider perspective as well as from legislative and regulatory perspectives. Legislation and regulations governing care often describe services broadly, i.e., "mental health services," and populations as "mentally ill" or "at-risk." Legislation and regulations also result in significant differences in what services providers are authorized to provide. Although both social workers and clinical psychologists provide mental health services to adults, only the social worker coordinates supportive services (employment, housing, education) for clients.

What one provider calls "family-centered care," another provider calls "wrap-around services." Both center on the child and family as the focus of service provision; both work with children who have special needs. Wrap-around, however, has been designated a "promising practice" by the federal government; family-centered care has

not. Family-centered care focuses on children with all types of chronic health problems. Wraparound focuses on children with serious emotional and behavioral problems. Considering the stigma attached to mental illnesses, a provider may prefer to say it is family-centered to the public, yet work within the wraparound framework. Hence, it is important that providers and persons receiving services have a shared understanding on what a service is called and what actions occur during the services provision. Since it makes a difference in practice, the discourse of public policy has material consequences. Ergo, conversations such as these *make a difference* in people's lives.

By examining how participants make sense of a phrase, my brief example above begins to make visible one of the many invisible interactions that occur in public policymaking. Interim and final reports do not show how members of a commission constructed a final understanding of terms, phrases, issues, and possible solutions. In addition, these same reports -- the product created by the policymaking process -- do not show us how decisions were reached, which experts or evidence were found wanting, whose voice(s) were preferred or dispreferred, or who or what had agency. It is within this dramaturgical 'backstage' setting (Goffman, 1959) that important differences in the public policymaking process are shaped, contextualized, and situated. It is there we see how individuals and groups determine and define a concern as a policy problem and how that determination creates specific patterns of interaction and involvement.

In a traditional analysis of policymaking, we examine the discourse of public policy from an endpoint perspective, i.e., the final product, often a report, accomplished by the members of a task force or commission. However, I choose a different type of analysis. I choose to analyze sensemaking (Weick, 1995) as a discourse dynamic in the

construction of the disembodied voice of "policy." This single voice accounts for the work of the group and substantiates its choices.

I show how a Communication perspective, and specifically a discursive approach, provides us the ability to better understand the policymaking process, not through the perspective of the infamous "black box" (Hajer, 2003), where people, time, effort, and energy are put into the box, the top is closed, and voila! Policy is created. Instead, a discursive approach shows us how participants in the public policymaking process jointly contextualize, situate, and construct meaning and a shared understanding of the issues before them.

The shared understanding necessary to formulate policy is crucial to persons who are responsible for policy decisions and recommendations. Prior to any formulation of policy is a visioning process to set goals and purpose. It is within this visioning that the members begin to co-construct meaning, share values, and formulate a framework that guides their process. The vision must be coherent and "sensible," not only to the participants within the group, but also to the larger publics who will implement the policy or who will be affected by the policy. The construction of the vision is the first step in a little "c" commission's transition from polyphony to the single voice of a big "C" Commission. To effect this transformation successfully requires an understanding of discourse and discursive practices in how individuals experience their worlds, legitimate knowledge, and reconstitute themselves as agents of shared knowledge.

Discourse is an "oscillation" between the everyday language of social interaction and language "used in some context for some purpose" (Fairclough, 2003, pp. 2-3). Since social practice is centered in the "oscillation between the perspective of social

structure and the perspective of social action and agency" (Fairclough, 2003, pp. 2-3), discourse is embodied social practice (Fairclough, 2003). It is part of the social activity within a practice, for example, providing therapy is using language in a particular way.

Discourse is embodied in representations. Performing an activity at work, social actors not only produce representations of other practices but also reflexively produce representations (Fairclough, 2003). Implementing an evidence-based practice requires social actors to recontextualize an external practice into their own practice and each actor will represent them differently. Discourse also is embodied in "ways of being" (Fairclough, 2003, p. 206). Consider how identity is constituted in the case of a person with a mental illness. The designation of "mentally ill" brings with it a host of attributes, which may or may not be correct.

The analysis of discursive practices within public policy allow us to examine how discourses are contextualized and which discourses, events, and practice are privileged or excluded (Fairclough, 1992). We can see little "d" discourse (language-in-use, e.g., conversations, narratives, or storylines) and big "D" discourse (identification with a group or a meta-discourse) (Gee, 1999) as simultaneous (real-time) or penne contemporaneous (reflective) events, each informing the other. With no discrete boundaries, discourses form human history. Through discourse, we can account for the ways in which participants construct their views, the subtle differences found in the expression of their views, and insight into the ideology or belief system of stakeholders and actors (Schön & Rein, 1994; Tuler, 2000).

Members of a group use a variety of sensemaking strategies in order to form an image of the reality in which they find themselves. Sometimes this reality – the system in which they are situated –remains constant. Sometimes change occurs. How such change occurs requires us to understand the social constructions of the political actors and their respective policy institutions. It requires a focus on the numerous discursive strategies used by individuals and institutions-- rhetorical argument, spoken and written discourse, and narratives -- that frame policy questions, contextual argumentation, and normative presuppositions to understand the socially co-constructed reality.

Discourse creates the *world of policy*. Discourse plays a key role within policy formation; political discourse is *made visible* within particular discursive (spoken and written) practices. Hence, mental health policy is the endpoint of a discursive process and that it is, in itself, an institutional process. These are the academic reasons for this dissertation. However, there are also personal reasons for this choice.

Why Do I Study Public Policymaking from a Communication Perspective?

As the director of the Research Library of the Florida Mental Health Institute (FMHI), I provided research services to faculty and research staff from 1990 to 2011, with a particular focus on health services research and policy. I conducted reviews of the literature, wrote policy analyses, identified trends and impacts, and did my best to support the mission of FMHI: "to improve the lives of people with mental, addictive, and developmental disorders through research, training, and education." Of the many policy issues I have researched, how a policymaking body decides and recommends a course of action was and is the most fascinating.

When I first began working at FMHI, it was a residential treatment facility for adults and a day treatment center for adolescents and children. I worked daily with our clients when they came to the library or when I went to the units to bring a book truck to those individuals who did not off off-unit privileges. Since many of the clients were long-term residential clients, they saw the library as a safe haven and its staff who were "like normal people," like them. They became friends. I knew their names, what they liked to read, and often their past and their hoped-for futures. I saw them at the cafeteria where we all ate. From our conversations, I learned that mental illness has many meanings. For each of the clients trauma, deep-seated fears, and vulnerabilities emerged with the experience of mental illness. Some of their fears related to what they were afraid of losing or had lost already: jobs, families, themselves. I also saw how quickly a normal conversation changed into a crisis-handling conversation when a client had a psychotic break off-unit. He or she would be gone from the library for days, weeks, or months. Sometimes they would be 'like normal' when they returned; sometimes not. Either way, I celebrated with them their regaining of off-unit privileges with their return to the library.

Amanda was one of the first people I met who was on the residential unit at FMHI. She was 48 when I met her. She had literally been in and out of institutions for over thirty years, after her first psychotic break. Her story is similar to so many of the stories I have heard over the years. Their lost dreams of finishing high school, of college, of family, of having a job, of living in their own place. The hope all of them had that this time the treatment would work, that they could have the life they wanted. I listened. I helped them find books and articles on treatment, on jobs, on anything they asked. I

provided a supervised work environment so clients could gain skills and knowledge. I wrote letters of recommendation. I trained clients in how to use the library to find information. When the residential units closed in the mid 1990s, I provided the same supports to our clients in FMHI's community treatment programs and began an active program of research and teaching.

As a librarian, my research interests lay in classification and cataloguing. I classify and categorize by name, subject, and authority, naming and creating relationships among things, individuals, and institutions. However, categorization is also about understanding the attributes, the "why" of the naming and relating of things. The knowledge that is associated within a category is culturally shared to the point that the simple mention of a category, such as "a person with mental illness" or "mental health professional," produces expectations of what the persons belonging to it are like and how they should behave.

I also know how simple it is to transition the focus from person as the 'object' of treatment to person as the individual choosing a particular action. Words have power to engage us in actions and understanding. The explicit and implicit expectations of the categories of PERSON and TREATMENT frame how helping professions, persons with psychiatric disabilities, and how social services systems operate. These categories also frame the information necessary for each group, as institutions –current and historical, *to operate* and *to know*.

I began to investigate the architecture of services and the roles of those who participate in its design and construction. My work on mental health parity took me into numerous community mental health communities. As I worked with advocates, family-

members, and peer-run groups, the lines between "helping professional" and "consumer" blurred. Writing the parity reports for the Florida Legislature, I struggled to retain the significance of individual accounts, without reducing the layers of complexity of the individual and where he or she is situated to a single generalizable statement. If the personal accounts and the scientific accounts made sense to me, how could I ensure it made the same sense to the legislators who held the power to improve the daily lives of persons with mental illness?

Then the Florida Commission on Mental Health and Substance Abuse was created and my interest in the formation of mental health policy grew. Since the Chair of the Commission, David Shern, was also the Dean of FMHI, the daily operations of the Commission were conducted at FMHI. Not only did I provide research support services to the Commission, I was to archive Commission documents and video on a publicly available website.

Many years later, I entered into the graduate program in the Department of Communication at the University of South Florida. It was in this program that I gained theoretical and analytical knowledge that eventually would allow me to integrate my interests in how public sector mental health policy was enacted and to "make visible the invisible" process of policymaking.

Why this particular topic? Over the past twenty years, I have learned the distinction between recovery of mental health versus recovery from a mental illness. I have seen first-hand and been involved in the efforts involved in trying to change the system. I believe in improving the quality of life for persons with mental illnesses. It is a mission of hope, a mission of consequence. A mission I support in my work at the

College of Behavioral and Community Sciences and in my studies in the Department of Communication.

I see many benefits of this twinned approach. First, a communication framework helps me rethink the roles that practitioners and academics play in generating knowledge in the field. Second, I have new ways of thinking about the social languages and user constructs that are important components in the design and implementation of services. I gain an appreciation and tolerance of our different worldviews, interpersonal styles, and contributions to research or community. However, perhaps the most important contribution is the opportunity to improve conditions and outcomes related to health and well-being, not just individuals, but of entire communities. Hence, my interest in how policy is formed.

In the first chapter of this work, I discuss the evolution of the scientific paradigm in the traditional approach to the analysis of public policy and the growing influence of a discursive approach to policy analysis and policymaking. Three major constructs are essential to understanding the policymaking process and serve as the framework for my study: 1) how communication genres (spoken and written discourse) contribute to the process of public policymaking, 2) how evidence and expert are constructed, and 3) how textual agency provides accountings of and for the policymaking process.

In Chapter 2, I describe my data in detail and substantiate my reasons for using a discursive approach. The data come from a legislative action. The Florida Legislature, in House Bill 2003, charged the Florida Commission on Mental Health and Substance Abuse to conduct a systematic review of the services systems and provide recommendations to bring the systems into the best of current knowledge and practice

In Chapter 3, I examine the communicative chain of text and talk. By this phrase, I mean the way in which agents engage in and create discourses through the inter-action of talk and institutional documents. I examine the interactions among the Commission, its support staff, and the many discursive communities in the public mental health system in Florida, focusing on the Commission's "Mental Health: State of the Science" meeting on 27-28 February 2000.

In Chapter 4, I examine the attribution of "expert." To be expert, an individual must be seen as legitimate, with the appropriate credentials, to participate in the evidentiary and decision making process. Professional credentials or life experience are two ways by which an individual is deemed "expert." However, objects, i.e., the text itself, can be ascribed the status of expert and evidentiary. Nowhere is that more evident than in the public policy making arena where expert and evidence are fundamental to the construction of a policy discussion.

In Chapter 5, I show how the interim, workgroup, and final reports of the Commission were written for a specific audience, within specific institutional structures, and how each was influenced and adapted to a specific set of norms, attitudes, and values. I show how the talk and testimony of the Commission and public stakeholders were reframed into a specific discourse resulting in the generation of texts and agency.

In Chapter 6, I suggest close readings of text and talk offer a better understanding of the discursive construction of the public policymaking process. We are able to see how individuals come to create the single voice of a Commission in the framing of an identified social problem, how expert and evidence are constructed, and how the agency of texts simultaneously is constrained and constrains. I conclude with a discussion on the

value of a discursive approach in public policymaking and as a complement to traditional policy analysis.

CHAPTER ONE: POLICYMAKING & POLICY ANALYSIS

> We as a Nation have long neglected the mentally ill … This neglect must end, if our nation is to live up to its own standards of human compassion and dignity. (President John F. Kennedy, 5 February 1963, Television statement on Special Message on mental illness and mental retardation).

Overview of Public Policymaking

How does public policymaking work? Lynn (1978, p. 17) states, "Policy making is not an event. It is a process." This implies both bad news and good news. Numerous factors determine who selects what topic. Frequently it is the public perception of an issue brought to the attention of politicians either by grassroots initiatives or through attention by the media. However, to start the policymaking process is relatively easy. At the system or macro-level, someone or something -- an individual or an institution or a piece of legislation -- identifies a problem and puts forth recommendations for a change. Someone or something codifies this change into laws and regulations. After an (un)specified amount of time passes, someone or something calls for an evaluation of the change. After someone conducts the evaluations, he or she (in an institutional capacity) makes recommendations for modifications. Then, someone or something -- an individual or an institution or a piece of legislation -- identifies a problem and puts forth recommendations for a change.

At the group or meso-level, the policymaking process includes the selection of an individual, a group of individuals, or an institution to examine the problem and to

generate recommendations. To do so, the now "working group" requests one or more policy analyses, depending upon the complexity of the problem and the scope of its mandate. Since policy analysis formulates policies and proposals using a variety of models, the type of analysis uses a specific language, be it economic, political, or social, to define and describe the problem and possible solutions. The working group then incorporates the analysis into its deliberations. Once the working group has completed the process and made its final report, an oversight agency conducts an analysis of its recommendations and process. This particular agency is often an external agency or the Executive or Legislative branch of a state or federal government. Central to the policymaking process, however, is the analysis of the issue, which is conducted to provide a background of the policy problem and options for change.

The Continuum of Policy Analysis

Lane (1972, p. 71) defines policy analysis as "the answers to the question: What happens when we intervene in the social system this way rather than that and why?" Policy analysis, as we know it today, emerged during the 1960s and early 1970s. Built upon the use of science and science-based information popularized by Lerner and Lasswell (1951) in the 1950s, policy analysis practice became an important component in state and federal government. The use of science-based knowledge allowed policymakers to argue successfully for the legitimacy of their actions.

Policy makers made use of "research brokers" as translators of the intellectual products of the research community into the language of policy (Sundquist, 1978). The involvement of the scientific research and academic communities was critical to obtain access to the evidence necessary to argue a particular policy decision. Policymakers

deemed a scientific policy analysis as an essential component to the clarification of issues, alternatives, and consequences in policymaking (Davis & Salasin, 1975; Weiss, 1979). Comprised of a trinity of "theory, empirical knowledge and analytic craftsmanship" (Lynn, 1987), policy analysis became "prescriptive." A prescriptive analysis actively recommends how a policymaker should use the data in his or her decision-making, "a way of speaking truth to power" (Wildavsky, 1979, p. 126).

By the 1980s, analytical studies of problems and the use of program evaluations became commonplace (Heineman et al., 1997). It was during those years that the field of policy analysis grew from a relatively few narrowly focused practitioners to a growing number of think tanks, government institutions, and universities. However, by the 1990s, the emphasis shifted slightly from a didactic model to a model that described and explained the kinds of inquiry in which policy makers engaged and for what reason (Lindblom, 1990; Schön & Rein, 1994). The popularity of policy analysis and policy-relevant scientific research "speaking truth to power" strongly reinforced the notion of the "knowledge for action" model (Argyris, 1993). Knowledge for action used scientific research and economic analyses to ameliorate or correct identified policy issues and subsequent programs.

Criticisms of Policy Analysis

Traditional policy analysis is criticized for its focus on purely objective, scientific, economic, and politically expedient solutions. Quade (1964, p. 301) warns us "the difficulty lies more in deciding what ought to be done than in deciding how to do it." Nelson (1977, p. 79) criticizes traditional policy analysis for ignoring stakeholder disagreements and interests, advocating for a more "open-ended evolutionary way in

which policies and programs do and should unfold." Banfield (1980, p. 18) argues that professional analysts focus more on the mastery of analytic techniques than explaining the issue at hand. A "value critical approach" is offered by deLeon (1997) in which "ideology, values, and belief become part and parcel of the formal analysis" (p. 79).

The view of the value of science and research has changed. Science now is seen as a product of the social world, "grounded in and shaped by normative suppositions and social meanings" (Fischer, 1993, p. 167). Evidence, argument, and persuasion, key factors in scientific policy analysis, are viewed differently in the interpretive (social) sciences (Majone, 1989).

Policy analysis is sustained by the particulars of the contexts in and for which it is carried out. Unger (1975, p. 112) notes that the empirical sciences "distinguish clearly the dimension of their subject matter from the dimension of the theory with which they describe it." Facts and data are distinct from model, theory, and subject. The social sciences, however, situate their subject matter and their accounting of it within a broader framework of model, theory, intentions, and values. As social science-based policy analysis became accepted practice, the larger question was *how* social science-based policy analysis will inform government action (Lynn, 2001).

A Discursive Approach in Policy Analysis

The shift to a social science-based policy analysis requires changes in the process of policy analysis. Policy analysts constrained by using the "normative economic paradigm" (Radin, 2000, p. 115) fail to provide policymakers with a contextualization of the policy issue within a larger governance or societal framework. Policymakers therefore lack legitimacy in the eyes of their constituencies, with only a superficial

understanding of programs, alternatives, and implementation. If the formal hierarchical process has limited applicability in helping to solve today's policy problems and issues, what are the alternatives? Making an argument using empirical science does not situate a policy problem against a "background of intentions and values" (Unger, 1975, p. 112). The value of an interpretive approach is its situation of the subject matter and the accounting of it "within a single, continuous" framework (Unger, 1975, p. 113). Hence, the discourse of policymaking is best seen as a constitutive and constructive process. This process accounts for complex institutional frameworks, in the context of multiple actors, multiple levels of meaning, and external and internal pressures (Edelman, 1964; Kingdon, 1984).

Much has been written on the discursive nature of policy analysis, particularly in the framework of a "crafted argument" (Stone 2002), as rhetoric, argumentation, or advocacy (Fischer 2007), or to illuminate "the contentious dimensions of policy questions, [or] to explain the intractability of policy debates" (Hawkesworth 1988, p. 191). Other researchers who study public policy emphasize "the processes by which policies are made and implemented rather than the substantive content and impacts of policies themselves" (Weimer, 1998, p. 182). Schön and Rein (1994), for example, suggest it is how the individual or institution makes the "normative leap" -- from *should* to *ought* -- that is of most interest in the policy process.

Unfortunately, as Hajer (2003) would have it, there is an "institutional void" inherent in the policy process as there are no clearly accepted rules or norms by which policymaking is conducted. Sacks (1992) notes that "from close looking at the world you can find things that we couldn't, by imagination, assert were there" (p. 420). An

ethnomethodologist, Sacks developed a particular formal approach to the examination of talk in everyday interaction. He claimed that the fine-grained analysis of talk-in-interaction makes visible the social interaction among participants. To me, "close looking" means to be able to formulate claims as to how the elements of communication are constituted reflexively within the act of communication (Deetz, 1994). Hajer (1995, p. 44) describes policy discourse as a "specific ensemble of ideas, concepts, and categorizations that are produced, reproduced, and transformed in a particular set of practices through which meaning is given to physical and social realities." And Yanow (2000) suggests actions and artifacts, such as texts, provide insight into policy discourses, reflecting different interpretations to the conceptual resources of the stakeholders.

In order to be able to "see" the construction and representation of positions of stakeholders in a specific decision-making event, it is critical to make sense of how an issue is "problematized," how information is analyzed, and how stakeholders integrate information to determine best practices. Therefore, it is important to observe the discursive interaction of policymakers: how participants deliberate solutions and, during the process of deliberation, negotiate consensus. The discipline of Communication provides us with a framework from which to approach public dialogue on complex and value-laden policy issues as a visible, empirically dynamic process.

Why Discourse Analysis

Discourse analysis, "the study of talk (or text) in context" (Tracy, 2001, p. 726), examines properties of language, as well as the patterns of its use, in the context of particular social situations or events (Tracy, 1999). Using this way of "close looking at the (social) world" (Sacks, 1992, p. 420), it is possible to take account of the ways in

which participants construct their views around problem identification, the subtle differences found in the expression of their views, and insight into the ideology or belief system of stakeholders and actors (Schön & Rein, 1994).

To understand the consequences of a policy requires the addition of local knowledge or the "mundane, expert understanding of and practical reasoning about local conditions derived from lived experiences" (Hawkesworth, 1988). Certain conversational moves are identifiable as interactional strategies, either at an individual identity level or as a group-level dilemma (Tracy, 1996). Since individuals and institutions construct public policy using institutional and social language "shorthand," these politics of representation (Mehan, 1996) influence stakeholders across political, economic, and societal dimensions. These representations greatly influence whether members buy-in to a particular argument, expert, or piece of evidence, and at what level.

There are numerous policy discourses, for example in public sector mental health, that belong to numerous professional and institutional communities. Each of these communities has its own discourse, with a specialized vocabulary, ontology, and epistemology. Take the vocabulary of the discipline of Social Work. How the discipline of Social Work frames *how it knows the world* and *how it knows it knows* is very different from how the discipline of Communication may frame *its* understanding of the world and *how* it knows. This also applies to how Social Work "understands" Communication and what is meant by knowledge. Although there may be sharing of a theorist between disciplines, terms and phrases still may need clarification, as in the example of Mary and Bob's discussion about the "continuum of care" in the introduction.

As stated earlier, there is an unspoken belief that public policy problems are far "too complicated for ordinary people to deal with" due to "the almost infinite complexity and ambiguity" of the identified problem (Banfield, 1980, p. 18). Because of the complexity of the issues in public sector mental health services, policymakers request policy analyses that inform them on the salient issues and concerns surrounding the identified problem. Policy analyses bring forth expert witnesses and scientific evidence to substantiate the claim that, for example, decision A is better than decision B, C, or Zed. In short, policy analyses "create problems that decision-makers are able to handle" (Wildavsky, 1979, p. 16) with available resources and within an allotted time.

However, an important consideration in a policy analysis is its audience. Audiences in policymaking range include the policymakers themselves as well as numerous stakeholder communities. What roles do identity and membership in a stakeholder community play in the policymaking process?

Identity, Communication Communities, Genres, and the Policy Process

In the world of public policy, there is not just a "one and true" policy discourse. Members of a policymaking group come from numerous lay, professional, and institutional communities, each with its own identity, its own vocabulary, its own "ways of doing," its own "ways of knowing," and its own understanding of "how things work." Each community has its own social and individual identity; it is situated in a social space, such as an agency or an institution. Each community also ascribes certain attributes to itself to make it distinctive. These "ways" of doing and knowing are rooted in the "identity" of the individual and the collective of individuals, the group.

Goffman (1959) asserts that identity is a continuous process, a "becoming," as we negotiate, create, and perform socially meaningful relationships. Jenkins (2004, p. 18) defines identity as the "systematic establishment and signification, between individuals, between collectivities, and between individuals and collectivities, of relationships of similarity and difference." Simultaneously internal and external, we project how we wish to be viewed while others (individuals or institutions) perceive and interpret our projection. Identity not only provides a shared cognitive frame and ready-made symbolic and discursive resources that may encourage or constrain agency, the shared perspectives of identity inform everyday practices, which, in turn, reproduce social structures.

Shared vocabularies, grammars, familiar patterns, and genres of identity are the product of the interactions they facilitate. Just as a genre in literature describes a category of literature with defining characteristics (e.g., poetry, prose, or drama), a genre of identity is a category of identity that has certain attributes, conventions, and agency. Goffman (1959, p. 3) suggests that an identity claim is an effort to control the conduct of others toward oneself, a demand to be treated in a certain way, as a certain sort of person. For example, an individual who self-identifies as a consumer of mental health services sees the world very differently than an individual who self-identifies as an ex-psychiatric survivor. Finally, individual identity also utilizes group identity(ies) as a means of his or her construction. These group identities become resources individuals may call upon when necessary to create language, beliefs, and values.

A collective or group identity is constructed around specific traits and agency, which are perceived to distinguish one group from another. Collective identity is a more fluid and adaptive social construction, which helps it achieve legitimacy as a group or to

earn societal or political recognition. The Florida Commission on Mental Health and Substance Abuse, for example, was granted pseudo-legitimacy as a corporate body with its establishment by HB 2003. A corporate body, however, does not equal a collective identity. The Commission had to co-construct its collective identity before it could speak effectively as a single voice.

A collective identity changes the resources and rules individual or social identities utilize. Unlike individual identity, a group identity forms over time through interactions among its members. In the case of the Commission, it had one year to create its identity. Collective actions generated through a group identity have a larger social impact than an isolated individual action generated through an individual identity. It is difficult for a single individual to be heard over all the other voices at a table, each voice clamoring for resources and services.

A collective identity may be transient or long-lived and be subject to modification or transformation. However, a collective identity is an object of orientation and interaction for its members during its existence. Consider the Chair of the Commission, David Shern. His identity as Dean of the Florida Mental Health Institute was a resource in establishing his credentials as someone knowledgeable of the state mental health services system and advocate for change to the system. His identity as Chair of the Commission provided him leverage to meet with other state governments and with heads of federal agencies, as well as to provide expert testimony to the U.S. Congress, on issues in the delivery of mental health and substance abuse services.

Members of the United States mental health patient reform movements, for example, may frame themselves as consumer, survivor, or ex-patient. Although all three

terms describe a person who has experience with the mental health services community, each term frames his other experience differently. Each term also frames the identity of each community as distinct from another as well as how a community and its members make sense of their lived experience vis-à-vis the mental health system. Hence, each community has its own sensemaking processes, social constructs, and discourses comprised of values, the importance of that community, and the "inclusion of difference" (Arnett & Arneson, 1999, p. 295). As these communities come together in task forces or commission, they forge new collective identities and generate collective action necessary to problem-solve identified social issues.

Borrowing from the attributes of a collective identity, Gunnarsson (1997) defines a "communication community" as a group, which shares norms, attitudes, and habits related to both spoken and written communication. Further, the socialization of such a community includes the acquisition of knowledge about and attitudes towards the patterns, functions, and so forth of both spoken and written language. Gunnarsson's (1997) analytical construct of a communication community addresses expert and everyday communication and stresses process as well as product. She also addresses two specific communication genres, i.e., spoken and written discourse, which she sees as essential elements in group culture and interaction. A communication genre, like other genres, is a category of identity that has certain attributes, conventions, and agency.

A communicative group chooses to use one communication genre over another based upon a number of factors. Spoken discourse, for example, has greater immediacy in its use with local audiences. Written discourse, created for audiences at geographic and diachronic distances, is a standardized discourse, based on a community's preferred

patterns of writing (e.g., academic communities). However, with the advent and use of internet, spoken discourse is available to distant communities through streaming technologies and written discourse is available immediately through social media and electronic mail.

As communities engage in talk and texts, they interact with other members of other communities to communicate and initiate new talk and texts. By tracking this communication in terms of organizing (Cooren, 2004), we are in fact tracking the (inter)actions that maintain and further a discourse. Not only can the links between a policy or change paradigm be determined; Gunnarsson (1997) and Cooren (2004) suggest that it is possible to connect these links together to create a chain of previous, current, and future discourses. A policy discourse, that formulates and subsequently implements a policy, can be followed to its impact on future discourses. Texts generated in earlier policymaking, for example, can be tracked as they are incorporated into current policy discourses. I argue that by disentangling those discursive chains many aspects of the public policymaking process can be made visible, including the organizational practices or rules for acceptable input into the policymaking process, the interrelationships in terms of distribution of resources, and how well a policy making body functioned organizationally (Linney, 1986).

Berkenkotter (2001) suggests, "Professions are organized by genre systems and their work is carried out through genre systems" (p. 327), allowing us to explicate specific discursive practices in the context of interrelated genres. Berkenkotter describes genre systems as types of social actions and situated cognition. Genre knowledge is procedural or background knowledge, which allows its users to communicate effectively

with each other and to reproduce a community's "norms, epistemology, ideology, and social ontology" (Berkenkotter & Huckin, p. 501). By studying these discursive practices, my aim is to "bridge the macrolevel perspectives of the social structure as shaping and determining human activity … and the micro-level perspectives of situated, every day practices as constitutive of social structure" (Berkenkotter, 2001, p. 328). These discursive practices show how a policy decision is contextualized, based upon the situatedness of a person, a place, or historicity of an event. How a consumer and a mental health provider co-construct the meaning of the term "continuum of care" provides insights in how each will construct a claim or account for an action. More importantly, I can see how texts transform prior texts and restructure existing genres and discourses to generate new texts. This is particularly critical with the reconfiguration of public policy as discursive space. I suggest that such a reconfiguration better enables investigations into analysis of policy *as it is created*.

"Evidence" and "Expert" in Public Policymaking

Unlike those who do research for the sake of research, policymakers use a different approach. They commission mental health services research and analysis to fill an acknowledged gap in their own knowledge. Policy makers first identify the knowledge gap; then, they acquire services research, often in the form of expert witnesses and texts (Weiss 1979). Their next step is to interpret the research in the context of the policy decision. Lastly, they make their choice of policy alternatives (Weiss 1979). However, knowledge and beliefs are contingent and contextual as individuals "must integrate information deriving from a diversity of mediated experiences" in "… such a way as to connect future projects with past experiences in a reasonably coherent fashion"

(Giddens 1991, p. 215). Therefore, finding and using mental health services research is not linear but rather a series of back and forth interactions among a variety of sources.

In the public policy process, many individuals, ranging from expert witnesses to fellow stakeholders, provide information on many topics and in many forms. Further, policy systems often privilege rational or expert knowledge. Expert knowledge, such as the close relationship of governments with established think tanks, for example, is acceptable. Expert knowledge is "legitimate," often with little discussion of lay or non-expert experience. However, I suggest lived experience is expert knowledge, made legitimate by both the Florida Legislature (HB 2003, 1999) and the U.S. Surgeon General (U. S. Department of Health and Human Services, 1999). Hence, testimony by persons with mental illnesses and their family members provides insights into mental health policy unavailable from clinical studies.

Expert knowledge relies upon facts; however, not all facts are equal. An expert selects certain facts to convey a point of view, to buttress an argument, to favor one decision over another. Ideally, expert information broadens access to useful knowledge available in the research community to policy makers. Such information may be inaccessible to or unrecognizable by policymakers until it is crafted into "simple arguments that challenge practices and ideas that have simply become part of agency tradition, culture, and ideology — even in the face of common sense" (Nelson, 1989, p. 408).

Policy analysts and policy makers promote the use of research-based knowledge as paramount in policy analysis (Davis & Salasin, 1975; Weiss 1979). When combined with personal, professional, and institutional values, knowledge, and beliefs in decision-

making, however, policy makers find challenges and limits to the use of this knowledge as the sole argument to effect change. Consider that mental health commissions are comprised of members from lay and professional communities. Facts are no longer "immutable truths." They are "theory-laden" and open to interpretation. Take, for example, the following statistic on the prevalence of mental illness in the adult population: "1 in 5 people have a mental illness." It is accurate but only offers part of the statistic. The actual statistic comes from the Epidemiologic Catchment Area Study, a stratified, multistage area probability study. The study found that during a 12-month period, one in five people, aged 15 to 54 years in the non-institutionalized population experiences a diagnosable mental illness (Regier et al., 1990). Although the "1 in 5" shorter version is rampant in both the scientific and popular literature, only in certain discourse communities is this institutional shorthand contextualized appropriately. I suggest it clearly shows us how policy actions are not only dependent on actual knowledge of policy; interpretations of facts by policymakers reflect and sustain specific ideologies and beliefs.

We find experts and evidence in many places: the life-world experiences of policymakers, analysts, and stakeholders; legislative and agency texts, organizational practices and structures as concretized in text, and the interactions between the participants and the artefacts created by and for the policymaking group. How a group comes to define expert and evidence is complex. There must be consensus among the group. Consistency in viewpoint is critical in coming to consensus, for visions, for process, and for products. Members create consistency through discursive strategies,

which assist in differentiating intended messages, better positioning their causes, and serving as a barometer when interests realign.

Although policy process models examine relationships between stakeholders and institutions, they often neglect the relationship between experts and stakeholders in the policy knowledge process. There is little systematic investigation into the process of accounting for "why, when, and how" expert knowledge is utilized by decision makers, particularly *which* expert knowledge stakeholders use and/or create. I argue in this work that the use of preferred expert knowledge in reports and legislation are the final products of the public policy problem-solving activity. By carefully examining these documents, we have glimpses in how problems are explored during the policymaking process.

Entextualization, Recontextualization, and Public Policymaking

Weick (1995, p. 9) notes that public policy issues are "problematic situations, which are puzzling, troubling, and uncertain." Since definitions and practices in complex systems may be ambiguous and difficult to discern, individuals in a group orient to each other as they engage in authoring, interpretation, creation, and discovery (Weick, 1995) over time and with each other. Consider the exchange between Mary and Bob at the beginning of this chapter. It is only one interaction of many interactions. Twenty-three Commission members with multiple perspectives and objectives needed a process that allowed them a space in which to bring issues to the table and work through their concerns. The facilitator, Eric Eisenberg, created a space and process to facilitate participation of individuals whose social constructs or discourses appear incommensurate. By allowing the members to clarify ambiguous issues through strategic

discursive moves, he was able to help the members contextualize and construct a vision (Eisenberg, 2007) that shaped the final report.

Bartesaghi and Castor (2008) suggest that a microanalysis of communicative processes assists in contextualizing social and institutional asymmetries, and allows the analyst to see how disparate views from numerous participants create a cohesive vision or a consensual set of recommendations. Since spoken discourse and written texts are forms of both professional and institutional interaction (Tuffin and Howard 2001), context is "dynamic, reciprocally emergent … between professional and institutional practice and accounting in various forms" (Bartesaghi 2009, p. 159).

Text, as Silverstein and Urban (1996, p. 14) remind us, is a "structure of discourse … embedded in richly contingent social action." Entextualization, therefore, is "the process of rendering a given instance of discourse a text" (Urban, 1996, p. 21). Within the process of entextualization, "complex, contextually nuanced discussions get summed up in (and, hence, are entextualized through) a single word" (Mehan, 1996, p. 253). One example is the phrase "serious emotionally disturbed" and the results of its entextualization within the Education of All Handicapped Children Act of 1975.

Bower (1960, 1982) created the term "serious emotionally disturbed" (SED) and its definition in 1957. When Congress incorporated the term in P.L. 94–142, Education of All Handicapped Children Act of 1975, it created additional language restricting special education services to the eligibility of children who have "social maladjustment" disorder but who were not seriously emotionally disturbed (Cline, 1990).

In 1989, The Council for Children with Behavioral Disorders (1989, p. 180) issued a public statement that the exclusionary clause in the federal definition of

Seriously Emotionally Disturbed was "of particular concern." Although the Council also took the position that the appropriate phrase for children handicapped by their behavior and/or emotions is "behavioral disorders," advocacy efforts by the National Mental Health and Special Education Coalition resulted in the adoption of the phrase "emotional or behavior disturbance" in subsequent authorizing federal legislation (Forness & Knitzer, 1992).

Today, within the field of children's mental health, there is still no consensus on the appropriate term. The recontextualization of a child with "a mental illness" to a child with "emotional or behavior disorders" is now moving toward the phrase "a child with challenging behaviors." Still worse is the fact that when a child ages out of the children's mental health system, he or she no longer has an emotional or behavior disturbance. The now-adult child receives an "adult" diagnosis, which requires that he or she recontextualize identity as a "person with X" and learn the "adult" language of mental illness.

Consider the final report of the Commission. In it, talk among members of the Commission was entextualized, i.e., situated and interpreted, to have a particular resonance with the many stakeholders in the public mental health system. The Commission also recontextualized the report of the Surgeon General to substantiate the Commission's findings and recommendations. How a group accounts for itself in institutionalized talk, such as a final report, may be radically different as one way of accounting is preferred over another way. A discursive approach provides the tools to parse out these recontextualizations and entextualizations.

Making Sense of the Black Box of Policymaking

Of the many factors that affect policymaking in the public mental health sector, three appear to be the most complex: structure, funding, and accountability. Consider the structure of the public mental health system. The delivery of mental health services requires negotiation among numerous local, state, and federal agencies, each of which has its vision and procedures on the funding and provision of its services, and in maintaining its own institutional structure and beliefs. Any change in the existing structure will require new laws and regulations to amend existing laws and regulations, as well as to establish new procedures for services delivery at the client, provider, and agency levels.

Changes in the structure of services delivery often requires or results in changes in funding. Funding for substance abuse treatment centers and services are distributed through a separate funding stream from mental health treatment centers and services. To further complicate the issue, if a person is diagnosed with both a mental illness and a substance use disorder, the two disorders are often treated independently of each other in separate facilities, by separate providers, at different points in time. Who receives what service and when and where they receive the services is itself determined by who is funding what services, when, and where.

To be funded, however, an agency must show that it is accountable. With the emphasis on performance-based program budgeting, changes in services delivery result in new mandated standards for accountability, assessment, and outcomes. An overarching federal or state auditing office, such as the U. S. Government Accountability Office, or Florida's Office of Program Policy Analysis and Government Accountability,

is often the final arbiter of policy recommendations put into practice. It will determine if the program performance has improved, if money was saved, or if program activities are still appropriate. Hence, the performance of providers, agencies, legislatures, and policymakers is under increased public scrutiny. Citizens and voters also demand greater accountability for the resources they commit to government. They insist on objective data to prove or disprove the worth of government programs. If they are unsatisfied with agency performance, they will write letters, create referendums, or vote in new leadership. However, there are limitations to performance measurement. Performance measures are only useful in decision-making processes to the extent that they are used and that they answer the right questions. Program level measures help managers make decisions about employee performance, use of allocated resources, and their ability to meet the specific needs of their constituents. Agency level measures often focus more on outcomes than on outputs and inputs, although all three will be significant measures of agency performance. Executive level measures focus on outcomes almost exclusively, such as what programs are actually changing lives of state residents. Legislative level measures are often the statewide outcome measures that apply to running state government. These factors contribute to the success or failure of which recommendations for change are taken up and which may hinder any implementation of change.

What is Change?

However, for an organization or institution to be accountable for change, change must be measurable. To be measurable, change must be defined. Drawing from the Communication literature, Van de Ven and Poole (1995, p. 512) define change as "an

empirical observation of difference in form, quality, or state over time in an organisational entity." Although change may be viewed as incremental or strategic (Nadler & Tushman, 1989, 1995), magnitude and pace of change are important elements in assessing change (DeWitt & Meyer, 1998) as is the political dimension of change (Dawson, 2003). From a public policy perspective, there is processual and paradigmatic change. Processual changes, or first order and second order changes, are "normal" in that they occur within the overall terms of the accepted policy paradigm (Hall, 1993). Third-order change is an epistemological paradigm shift (Kuhn, 1970), in which a discipline discards its current paradigm for a new, often radical, change of a worldview.

Of the two types of public policy change, processual change is integral to this discussion. In first order (normal or routine) policy changes, there is no significant shift in the balance of power or redistribution of resources. Routine policy change is simply the tacit reinforcement of an existing understanding (Feldman, 1989) of a socially constructed issue, event, or action. An example of that is updating diagnostic criteria for a specified disorder, or adding a time-tested pharmaceutical to the state drug formulary. The institutional discourse may not change significantly (or at all) and any change will be consistent with present understandings.

Second-order policy change, which involves the development of new policy with strategic actions, poses the problem of how best to address the identified issue. Second order change affects existing values, legislation, regulatory requirements, organizational structure, cultural practices, and availability of resources. In addition, more stakeholders are affected. The recommendation of a statewide change to the delivery of public mental health services across all ages, all settings, and all providers increases the number of

stakeholders who will want to speak and have their views taken into account. More individual and institutional voices, more perspectives, and vocabularies result in more discourses, accountings, claims, and expectations.

For second-order policy change to be effective there must be conscious and specific directional change in the (co)construction of meaning by individuals. However, for second-order change to occur, discourses themselves are suspect, and must be examined carefully to determine core concepts and actions. Hence, analysis of an issue's complexity has a number of criteria depending upon the level of possible change to an existing order.

Making Sense of Change

Policymakers and policy analysts address this conceptual complexity when they study an issue. They make sense of the policy language and process, organizational and inter-organizational behaviors, internal and external perspectives, statistical data, public or invited testimony, empirical evidence, and other "ways of knowing." In mental health services, research, and policy, for example, the lived experience of persons with mental illnesses and their family members are other equally important "ways of knowing" about the effects of mental illnesses as reading the results of clinical studies or program evaluations. This sense-making provides insight for the stakeholders, helps them negotiate and cross institutional boundaries, define organizational interests, and interprets events and actions (Feldman 1989).

A crucial aspect of policymaking in practice depends upon the interactional dynamic and on the persuasiveness of the argument, i.e., which arguments advance, how sensemaking occurs, and which claims succeed. Public policy analysis uses a number of

ontological, epistemological, and methodological frameworks to support the policymaking process. For example, one should not reduce the question "what should we do to resolve X?" to questions about "what do we know about Y?" Knowing the structure of Y alone does not provide a solution to X. However, public policy analysis and policymaking often allocate much time to describing the structure of the system under study.

Epistemologically, policymaking is iterative. It generates and informs spoken and written discourses. Stakeholder communities generate and inform spoken and written discourses that affect policy decisions. Further, each of these communities has its own discourses, social world, sensemaking, constructs, and interactions among its members and with external communities. These spoken and written discourses may be fraught with ambiguity, and require clarification. Each community prefers and disprefers certain discourses over another, for example, the discourse of evidence over the discourse of lived experience. A discursive approach allows us to examine how a community creates little "d" discourse and big "D" Discourse.

Methodologically, a public policy commission is an authoritative institution linked to an identified policy problem. Depending upon the issue at hand, and who provides the analysis, different arguments, rules, and resources are advanced. Members use these tools to create a shared understanding, a common language, or a frame of reference of the identified policy problem or to disprefer one discourse or action over another. Policy makers use numerous resources to study an issue deemed problematic.

Studying an identified social issue allows institutions to accomplish two things. The institution, be it agency, legislature, or Office of the Governor, shows itself to 1) be

accountable to its stakeholders and 2) to show its concern about improving the welfare of its citizens. A study also requires little effort on their part. The legislative language of House Bill 2003 Section 4 establishes the Commission to perform a systematic review of the mental health services delivery system and make recommendations. The Legislature simply requests and receives the study; however, the Commission is accountable for conducting the study and its subsequent success. A successful study implicitly or explicitly provides credence and scientific legitimacy to concerns expressed by the lay public, practicing professionals, agency staff, administrators, and legislators.

Note that the Commission used a seminal text prepared by the U.S. Surgeon General as its primary document substantiating its claims as to the identified need for improved services at the national level, with state documents substantiating the need at a local level. During the year, the Commission brought in a number of professional and lay experts, who provided additional statistics and insider information on the viability of the current system, and accepted public testimony from additional stakeholders. The timeframe of a single year to investigate, determine best practices, bring in different people to weigh in from across the state, and subsequently to synthesize and write interim and final reports may seem like a lot of time. Considering the complexity of the mental health services system in Florida, the Commission early on had to select a handful of focal areas quickly and concentrate on gathering expert input and the best evidence available to aid in its decision-making process.

Public sector mental health focuses on prevention, early intervention, and treatment for acute and long-term (chronic) care for persons with mental illnesses. To create second-order change in the public sector mental health systems requires an

understanding of the communicative and organizational conventions within the systems. To do so, individuals interested and/or involved in the public policymaking process must first step outside the "what" that is identified as problematic. Next, they must carefully disentangle what maintains stakeholders' status and relationships to the problem and each other. Finally, they must understand how individuals affected and within the systems practice these conventions.

Examining a Local "Black Box"

In the 1960s, the consumer advocacy movement and the civil rights movement resulted in federal legislation that moved individuals from institutionalized care back into their communities. By 1999, the dream of deinstitutionalization had faded as persons with mental illnesses failed to integrate successfully into their communities. Further, the legislation failed to create integrated services delivery systems that addressed the individuals within the community, not just the illness, but also the social supports (housing, food, employment, education, rehabilitation, inter alia) which were formerly provided in the institutional setting.

In 1999, the Florida Legislature created a public policy commission to conduct a systematic review of the overall management of the state's mental health and substance abuse systems. Comprised of twenty-three statewide representatives from various stakeholder groups, the Florida Commission on Mental Health and Substance Abuse met across the state of Florida during 1999 to 2000.

To facilitate opportunity for public education and testimony, the Commission met monthly in different locales around the state. Each meeting had a theme and provided opportunity for open public testimony. Early meetings also included facilitated group

discussion and invited expert speakers. The final report, created by the Commission, was the culmination of a year of open deliberation and proposed changes to the existing public mental health service systems.

How this Commission created a shared understanding of the many issues involved in public mental health care, much less came to consensus on a set of recommendations, can best be discerned through a review of its meetings and texts. It is through a close reading of their documents and transcripts that we see how the Commission legitimated its decisions to improve the delivery of mental health services and to better the lives of persons with mental illnesses.

Summary and Conclusion

Hajer's (2003) suggestion that public policymaking takes place in an "institutional void" means that there are no clear, accepted rules or norms by which policymaking is conducted; we are limited to what we can see of the policymaking process. Consider the Commission. At a state policy level, a larger institutional body, such as the Governor or the Legislature, established a commission to study an identified problem. How does this happen? All we have is the language of the legislative text. The institution chooses individuals from a wide variety of stakeholder groups from across the state to comprise the commission and designates a chair. How do they choose? There may be minutes or correspondence that documents the decisions on who to ask, who accepted, or rejected the invitation and why they made that decision. The commission begins to study the problem. How do they study the problem? They gather evidence, listen to experts, engage in discussion, and generate texts, speaking for themselves or for institutions, across a defined period of time and at meetings across the state. We know this through

the spoken and written discourse of the Commission. The analysis of existing policy and the change that is possible forms the crux of the discourse of public policy. And this I show in my dissertation.

In this chapter, I have summarized what I see as the interdependence of communication and public policymaking, i.e., policymaking is a struggle over ideas and values, played out through the strategic use of language in interaction within multiple social situations, with expert bodies, testimonies, and supporting documents. Acknowledging the difficulties inherent in the policymaking process requires an acknowledgement of the importance of discourse to negotiate a shared understanding and to resolve conflict over individual and collective values, objectives, and beliefs.

The meaning of analysis itself has changed as analysts increasingly face socio-politico-cultural phenomena that do not fit easily into the more traditional scientific and economic modes of explanation. Further, policy analysis is intimately involved in changing both institutional and individual behaviors. Archibald (1980, p. 196) warns policy makers and analysts not "to take as fixed that which is in fact open to redesign." Ignoring possibilities for effective change due to a reliance on only one "way of knowing" creates serious consequences in the policy process and in its subsequent implementation. A focus on discourse as social action allows policy analysis to have a contextual orientation, which allows close examination of the talk and text generated by such a process.

The overall importance of institutional discourse lies in its multiple meanings and the scope for contesting meaning aroused by these many layers and perceptions. Further, multiple stakeholders use a variety of discursive strategies to minimize personal,

organizational, and political risk as they engage in making sense of the identified problem and possible solutions. In the analytic chapters, I examine how talk (social interaction) and text (talk institutionalized into text) are linked inextricably in the policymaking process, the use of evidence and expert in creating a shared understanding, and the transformation of a multi-stakeholder document into a single voice. I show how these connections work together to produce meaning. Such an analysis can be expanded to not only implicate philosophical or political debates, domains of knowledge, and practices, but to understand better how members of a policy group create policy, as a group, in real-life settings. In Chapter 2, I provide a detailed examination of the data and the method that I will use in Chapters 3, 4, and 5.

CHAPTER TWO: DATA AND METHOD

> Where policy making and politics take place in an institutional void we should pay attention to a double dynamic: Actors not only deliberate to get to favourable solutions for particular problems but while deliberating they also negotiate new institutional rules, develop new norms of appropriate behavior and devise new conceptions of legitimate political intervention (Hajer, 2003, pp. 175-176).

Reminiscent of the cartoon in which a scientist writes a complex equation on the board and in the middle he draws a cloud and writes the words "then a miracle occurs," the "institutional void" referenced above reminds us that the dynamics of the policymaking process is invisible to many of us. Hence, as Hajer instructs us, it is critical to pay close attention to the dynamic of the process to understand how policymaking occurs. How can we understand the process of deliberation, negotiation, rules, solutions, and behaviors across individuals and institutions represented at a policy table by means of a Communication framework? This chapter tackles this very question.

I provide a description of the data and the method that I use to describe the communicative chain of text and talk. By this phrase, I mean the way in which agents engage in and create discourses through the inter-action of talk and institutional documents. Policy talk is accounted for and institutionalized in text. Silverstein and Urban (1996) remind us that when something (such as talk) is turned into a text, it is decontextualized from its original structure and meaning. Entextualization, the process

of rendering a given instance of discourse as a text, which removes it from the context(s) of the discourse (Urban, 1996), allows the talk to be shared among many individuals. The text, or portions of it, can be re-iterated (Derrida, 1988), which means that it reconstitutes meanings independent of its original situation; it can be cast as a durable object in its own right, or in its role as a durable object be reanimated through new contextualized interpretations (Silverstein & Urban, 1999). Recontextualization (re-framing or reorganization of a text) allows an author to substantiate new, and possibly different, claims made by the original author (Mertz, 1996). By disembedding the talk entextualized and recontextualized in institutional documents, I track how talk becomes text and text informs talk, linking the many discourses that occur during public policymaking.

In the following sections, I first, describe the Florida Commission on Mental Health and Substance Abuse. I provide a brief view of its founding legislation and mandate, its membership, and its activities. I introduce the potential actors, human and object and, more importantly, foreshadow the groundwork for the analyses in my successive chapters. Next, I describe the data from the Commission as well as the methods of analysis I will use for the three analytic chapters: the communicative chain of text and talk, the role of expert in public policymaking, and the transformation of a text to an academic voice.

The Florida Commission on Mental Health and Substance Abuse

The Florida Commission on Mental Health and Substance Abuse was created in 1999 by House Bill 2003 for the purpose of conducting a systematic review of the management of the state's mental health and substance abuse system. Because the state

of Florida has a Sunshine Law, which requires public documentation of state commission and task force deliberations, there is an extensive paper and video archive housed at the Louis de la Parte Florida Mental Health Institute and on the internet. The Commission used the internet as a way to make its work public to a wider audience. In addition, I oversaw the web archiving of the Commission public meetings and many of its working documents reside in the FMHI Library archive. Hence, I had the ability to examine, over time, how issues were brought to the notice of the Commission, and which issues were selected for further examination, as well as which documents were used to support the recommendations of the Commission. In order to explain the task and the output of the Commission, I provide a brief overview of its composition and its activities.

In 1999 the Office of the U.S. Surgeon General released its first-ever report on mental illnesses and substance abuse. In it, the Surgeon General provided an up-to-date review of the current advances in the scientific treatment of mental illnesses, the efficacy of treatment, the importance of prevention, and the organization and financing of care (U.S. Department of Health and Human Services, 1999). Later that year, the Florida Legislature passed House Bill (HB) 2003, which identified a public policy issue, specifically that how "mental health and substance abuse services are planned, purchased, delivered, and accounted for … had not been systematically reviewed or updated in over 15 years" (HB 2003, 1999, lines 5-16, p. 5). This lack, from the Legislature's perspective, had diminished "the potential efficacy of its investment in mental health services and substance abuse services (HB 2003, 1999, lines 5-16, p. 5). The Legislature established the Commission on Mental Health and Substance Abuse to conduct "a systematic review of the overall management of the state's mental health and substance

abuse system be conducted and that recommendations for updating part IV of Chapter 394, Florida Statutes, and other related statutes be formulated" (HB 2003, 1999, lines 16-20, p. 5).

Eighteen Commissioners were appointed by Governor Bush -- one was appointed by the Speaker of the House, and one was appointed by the President of the Senate. The remaining three members were appointed by the Secretary of the Department of Children and Families, the Director of the Agency for Health Care Administration, and the Secretary of the Department of Health. The twenty-three Commissioners comprise statewide representatives from various categories including mental health and substance abuse providers, hospitals, employers, insurance carriers, family members, and consumers of public services. The Dean of the University of South Florida's Florida Mental Health Institute and a former public sector administrator for mental health was chosen to chair of the Commission. A facilitator, a Communication professor at the University of South Florida, was selected to assist the Commission in its visioning process (see Appendix A).

In addition to the twenty-three statewide representatives from all across the state, the Commission Chair, and the facilitator, the Commission also had an Executive Director and a staff comprised from members of the Florida Mental Health Institute. The Commission chose a number of venues across the state to ensure as much participation as possible from stakeholder communities during the coming year. So as to facilitate opportunity for public education and testimony, the Commission met monthly in different locales around the state. The Commission also created a website to post its monthly agenda. The videotapes of each meeting were "streamed" on the internet to provide

access to the larger community of stakeholders who were unable to attend each of the local meetings. The meetings were divided into a morning meeting for Commission members and invited speakers and an afternoon meeting for invited and public testimony. Commission members and speakers referenced federal and state reports and distributed handouts from presentations or as added information for Commission members. In addition, the Commission generated Business Meeting Notes and Content Notes from each of its meetings. Nancy Bell, Executive Director of the Commission, and staff at the Florida Mental Health Institute (FMHI), prepared the Business Meeting Notes. Additional staff from FMHI prepared the Content Notes.

The Data

My data consist of

- videotapes, business meetings, and content notes of the Commission meetings,
- reports of invited consultants and experts,
- the interim and final reports of the commission,
- documents used as foundational readings on mental health,
- reports and documents from other states, professional organizations, and federal agencies; and
- Florida Statutes and legislative documents.

Extracts from these documents will be used in the three successive analytic chapters. The analysis of correspondence, videotapes, and reports are central to understanding how the role of text and talk determine the preference of some items over others, and how the construct of "expert" is created and sustained, including how the voices of persons with mental illnesses are transformed into a single academic voice.

The data represent the spoken and written discourses that were integral to the Commission's sensemaking process. Twenty-six individuals came together over the course of a year and accomplished a number of things. They created a collective identity. They asked experts for explanation. They reviewed evidence. They engaged in public dialogue. They questioned. They agreed and disagreed. They created workgroups. They synthesized all of these discourses and authored a text to effect change.

When looking at the data, there are similarities and dissimilarities I would like to point out. The data are similar in that all the data began as talk. From the talk among the Legislature that enrolled HB 2003 to the talk that formulated the selection of its members to the creation of the final report, the data reflects the numerous discourses of public policy. They provide accountings of work performed; they substantiate claims; they construct an understanding of X. However, the data are dissimilar from temporal-spatial and strategic viewpoints. Some data have immediacy and currency; it is real-time talk from people who are intimately involved in receiving treatment, providing services, or evaluating outcomes. Other data are strategic, in that it was created to prefer one solution at the expense of another, or to disprefer a course of action or use of language. Still other data are talk that has transcended time, such as the 1960's legislative language to initiate community-based care or the referencing of the 1999 U.S. Surgeon General's report on mental health in reports by subsequent Presidential Commissions, such as the 2003 New Freedom Commission.

The data are inextricable, however, as links in a communicative chain of written and spoken discourse, showing the connections among the agents in public policymaking. It is in these data we see who accounted for what, how one claim was preferred or

dispreferred over another, how the Commission's identity was constructed, and how meanings were created, as in the example of how Mary and Bob negotiated the meaning of "continuum of care" in the Introduction. The data allow us to reconstruct the social structures and interactions that determine what happens in the reality of policymaking and what enables or constrains "change."

Videotapes, Business Meetings, and Content Notes

Using the videotapes, I examine the dynamics of the group, in their discussions and decisions, as they tried to make sense of the task assigned to them. I analyze how the Commission works through building alliances and consensus. These (dis)agreements emerge through talk and are concretized in the development of texts. There were thirteen formal sessions of the Commission between 16 November 1999 and 15 December 2000. The first meeting, on 16 November 1999, was the Commission Orientation. Judge Kathleen Kearney, Secretary of the Department of Children and Families (DCF), spoke on behalf of Governor Bush and the State Legislature about the role of the Commission. John Bryant, the Assistant Secretary of the Mental Health Program Office in the Department of Children and Families (DCF) discussed the Commission's establishing legislation HB 2003, framed DCF's role vis-à-vis the Commission, and the deliverables of the Commission. Mr. Bryant also provided an overview of the Mental Health Program Office within DCF, followed by a presentation by Mr. Ken DeCerchio, Assistant Secretary for the DCF Substance Abuse Program Office. Robert Sharpe, Assistant Deputy Director of Medicaid in the Agency for Health Care Administration (AHCA) provided an overview of Medicaid funding for mental health and substance abuse

services. Mr. John Slye, DCF legal counsel, established the ethical guidelines and Florida's Government in the Sunshine Law.

During the November 1999 meeting, the Commission also established its vision and a working format to guide its activities during the next year. By the June 2000 meeting, the Commission established four Workgroups -- Data & Needs Assessment, Children, Adult, and Older Adults -- comprised of members of the Commission, the Commission Advisory Committee, consumers and family members, university/FMHI faculty and staff, and representatives from the state Department of Children and Families and the Agency for Health Care Administration. The remaining meetings included working sessions and reports of the Workgroups (**).

1. 13 December 1999: Mental Health, Substance Abuse, & the Legal System
2. 31 January 2000: Children's Mental Health & Substance Abuse
3. 28 February 2000: Mental Health: The State of the Science
4. 28 April 2000: Emergency Behavioral Health Care
5. 19 May 2000: Substance Abuse
6. 23 June 2000: Older Adults - Mental Health & Substance Abuse Needs**
7. 21 July 2000: System Architecture**
8. 28 August 2000: Financing/Rural Health Care**
9. 22/23 September 2000: Jail Diversion/ Quality of Care**
10. 13/14 October 2000: Prevention/Consumer Choice**

The final two meetings of the Commission held at FMHI (17/18 November 2000 and 15 December 2000) addressed the reports of the four workgroups and the drafts of its *Final Report*. These were the only two Commission meetings which were not videotaped

and did not have public testimony. Of the thirteen meetings of the Commission, I have chosen two meetings to examine. The first selected meeting is 13 December 1999: Commission Orientation and the second selected meeting is the 28 February 2000: "Mental Health: The State of the Science." These two meetings establish the parameters of the charge of the Commission and note significant aspects in how the Commission deliberated and generated its final report.

Numerous texts were read by the Commission in preparation for two deliverables: the Interim Report and the Final Report. Each deliverable went through numerous iterations: draft documents, working presentations, and additional text revisions incorporating Commission feedback. Although this iterability is a critical part of understanding the policy process, many individuals outside of the policymaking process do not realize its importance. It is in the iterability of the document, from draft to final form, that allows an individual to determine how changes are explicated, (re)entextualized, and (re)contextualized in the final document. Entextualization and recontextualization of talk engenders metadiscourse, or discourse about discourse.

Metadiscourse can be defined as an author's attempt to guide how the reader perceives a text, not only as content and information, but also as the results of a larger discourse. In short, metadiscourse is informing readers what will be said and how readers should perceive it. The statement, "this stretch of discourse is a text whose meaning is …" (Silverstein & Urban, 1996, p. 2), is a metadiscursive construct. It not only refers to the actual practice the text is performing but to specific discursive strategies by the privileging of one voice over another or invoking textual agency. One example of this metadiscourse is shown in my examination of the draft *Interim Report.* I review the

transcript of the "State of the Science" meeting, and the accompanying business notes and content notes in which the Commissioners review and comment on the draft report. In the transcript, two members of the Commission, Patsy and Michael, want the draft revised to emphasize that the themes in the *Interim Report* came from the public testimony. Patsy also asks for a close review of the testimony to ensure that the Commissioners were not missing any important issues that need to be addressed. After a somewhat lengthy discussion, David Shern, the Chair of the Commission, agrees with Patsy and Michael that the draft interim report should be amended to show that emphasis. He asks for a formal motion to amend the draft interim report. After a formal motion from the group, David states the interim report will be submitted to the legislature with the suggested changes ("State of the Science" transcript, Appendix A).

In the business meeting notes taken by Nancy Bell, the Executive Director of the Commission, she writes, "Patsy Holmes asked that past content notes be checked to be sure all themes were covered. Michael Spellman asked that it be made clear that public testimony had been integrated into the Commission's deliberations" (FCMHSA, 2000, February 27). The February content notes report a request by Patsy that the Commission staff examine the past content notes to ensure all themes were covered. Although Nancy Bell authored the draft and the revisions to the draft based upon this meeting, the final version of the *Interim Report* places the Commissioners as primary players in how the themes were developed:

> As Commissioners shared their individual perspectives on the current public mental health and substance abuse system and heard public

testimony, dominant themes and major issues began to emerge.

(FCMHSA, 1999, *Interim Report*, p. 2).

Public testimony is first viewed vis-à-vis the Commissioners' own understanding of the issues within the mental health and substance abuse services system and then through the lens of the facilitated discussions. What is not mentioned in the *Interim Report* is the themes in the vision statement were developed prior to any public testimony. I explore this incident more fully in Chapters 4 and 5.

Invited Consultants and Speakers

There were a number of discourse communities represented by the speakers, officially invited to attend the Commission meetings. I explore these data further in Chapter 4, where I examine the use of evidence in the construction of "expert." Individuals were deemed to be "expert" due to professional credentials or by life experience. Since mental health services (i.e., mental illnesses and substance use/addictive disorders) are provided by a wide range of professionals and peers in numerous settings, it was critical that experts from the different types of service settings be represented at the Commission hearings. In addition, the fact that attention was paid to how the experts present evidence, and the weight of that evidence, can be noted in the Commission's deliberations as it reviews its interim and final reports, which is further explored in Chapter 5. Each business meeting had an invited expert from the field as the first speaker, followed by additional speakers to give invited testimony on that day's designated issue. In total, fifty-nine invited speakers appeared before the Commission during the ten topical meetings in 1999-2000 (see Appendix B for the full list of invited speakers).

Speakers spanned the breadth of the mental health community, identifying themselves in a number of ways. Four speakers identified themselves organizationally: the Florida Council for Community Mental Health, the Florida Alcohol and Drug Abuse Association (2), and the Florida Association of Counties. Five speakers identified themselves as advocates, three represented NAMI chapters, an advocacy organization for family members and persons with mental illnesses, and two were attorneys involved in advocacy efforts. Eight individuals identified themselves by their academic credentials. Of those eight, three of those individuals were also involved in the preparation of *Mental Health: A report of the Surgeon General* (1999). Eleven speakers identified themselves as family members of persons with mental illnesses or as consumers. Twelve individuals identified themselves as mental health or substance abuse services providers. Twenty-two individuals were with eight different state departments or agencies in Florida: Department of Children and Families (DCF), Agency for Health Care Administration (AHCA), Department of Elder Affairs, Florida State Courts, Department of Corrections, Department of Juvenile Justice, Florida Department of Law Enforcement, and the Florida Office of Drug Control Policy.

How individuals identify themselves individually and institutionally is important. Since identity is emergent and indexical, how a person identifies him- or herself offers a glimpse of their languages, communities, and constructs of mental health, for example, in the use of specific discourses and discursive strategies to clarify how he or she understands an issue or in the communication of meaning through talk. As individuals account for their positions, i.e., situated 'accountings-for,' this data gives us privileged insights into how people conceptualize and engage in relationships (Baker, 2004).

Further, this 'data' represent the interactions of cultural knowledge and membership categories of the respondents. I address this further in Chapters 3 and 4.

Public Testimony

In addition to the invited presenters who spoke during the business meetings of the Commission, ten of the statewide meetings provided opportunity for any citizen to provide testimony or opinion to the Commission. The public testimony sessions ran between one to three and a half hours, with a total of 101 speakers, from a variety of discourse communities; thirty-four providers of mental health services were represented, of which six were peer service centers. Twenty-eight advocacy groups were represented. Five state agencies, including law enforcement, and oversight agencies, also spoke. At an individual level, sixteen consumers spoke, as did four family members, and five academics.

I use that public testimony, as reported during the business meetings of the Commission, to show additional discourses brought forward to the Commission from the professional and lay communities involved in mental health services in Florida. These discourses became part of the chaining of text and talk I discuss in Chapter 3, the invocation of expert in Chapter 4, and in the reframing of the consumer voice in Chapter 5.

Workgroup Members

I examine the activity of the four Workgroups to show how they were informed by the talk and texts that surrounded them in the creation of new discourses. These discourses were formalized in the texts each of the Workgroups created. This is important in that the Workgroups preferred specific discourses over others that were

accessible to Commission participants and which their members specifically brought to the table as speakers.

In addition to the invited and public testimony, four workgroups were established to prepare background reports and recommendations for the Commission. To ensure a range of perspectives would be included in each report, representatives were drawn from each represented community. The communities included the Commissioners, the Commission's Advisory Committee, Consumers/Family Members, USF-FMHI Faculty & Staff, DCF Representatives, and AHCA Representatives. Each workgroup addressed a specific area (Data & Needs Assessment) or a population (Children, Adult, and Older Adult).

I notice that there are two key exceptions to the composition of the workgroups. The first exception was the Data & Needs Assessment Workgroup, which was the only workgroup that did not have representation from a consumer or family member. The second exception was the Children's Workgroup. Robert Friedman, Chair of the Department of Child and Family Studies within the Louis de la Parte Florida Mental Health Institute, had also been a member of a larger Workgroup on the Surgeon General's report on mental health. Not only did he bring state-specific knowledge to the table, he also had an insider's view of the process and substantiation of the claims put forth in the Surgeon General's report.

In addition to a synthesis of their topic, each workgroup was to make recommendations for change. If a recommendation would affect an existing law or administrative code, the workgroup was to include in its report a listing of the affected legislation.

Other Reports and Documents

In addition to the testimony and spoken presentations, a number of federal and state texts were used by the Commission. Each of the fifty-nine expert speakers provided texts in the form of handouts, papers, or PowerPoints (print and/or electronic copies). In addition, many of the invited and public testimony participants also provided text, in the form of handouts of their testimony, program brochures, news clippings, newsletters, and personal narratives. Fifty-seven separate reports and white papers were provided to the Commission for their review. Additional texts, on specific topics or populations, were also provided to Commission members to read.

A primary text was the recently released *Mental health: A report of the Surgeon General*, written by David Satcher, then-US Surgeon General, the first-ever report by that office on mental health. Expert knowledge and evidence play major roles in informing public health policy. I raise several important questions here concerning the very definition of expertise and evidence. Namely, is any professional (expert) inquiry that assists in problem solving considered evidence? Is evidence only that research that is citable? Is evidence only that which is explicit, as in the randomized controlled study, or is tacit knowledge evidence? In Chapter 4, I show how the text, *Mental Health,* substantiates claims as expert and/or evidence, as well as the need for services, resources, or inclusion.

In addition to the academic research, agency reports, testimony, and ephemera given to the Commission, there was also review of the Florida Statutes, Chapters 394 and 397. These chapters address the provision of mental health and substance use services in the state of Florida. As stated previously, mental illnesses and substance use disorders

are treated in separate service systems; therefore each is addressed as a separate chapter in the Florida Statutes. Chapter 394, "Florida Mental Health Act" ("Baker Act"), establishes the legislative intent of the Act, and addresses the interstate compact on mental health, comprehensive child and adolescent mental health services, community substance abuse and mental health services, and involuntary civil commitment of sexually violent predators. Chapter 397, entitled the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993," addresses substance abuse services. This includes the general provisions of the Marchman Act, identifies service providers, and establishes client rights, voluntary and involuntary admission procedures, and local ordinance and authorization, admissions procedures. In addition, Chapter 397 also establishes protocols for offender referrals, inmate substance abuse programs, substance use services coordination, juvenile emergency procedures, and delineates children's substance abuse services. It is my contention that the statutes themselves hindered the ability of the Commission to recommend substantive and, more importantly, *implementable* changes in how mental health services are delivered in the state of Florida.

Consider the scope of the charge to the Commission. The Commission and the Workgroups were to consider changes to the delivery of services that are described and prescribed in legislative and statutory language. Questions regarding changes in the Acts required examination of the legislative and/or statutory history of the Acts. Further, the Commission reviewed numerous legislative staff analyses and impact statements prepared by legislative staff or submitted to House and Senate Committees for review, as well as House- or Senate-generated interim work program reports and summaries. These reports would not just examine Chapters 394 and 397, but also require the review of other

Chapters possibly affected by significant changes due to the restructuring, financing, oversight, and implementation of mental health and substance abuse services at either a state or a federal level.

The reason a review of statutory constraints is necessary is simple; a single change may affect numerous areas within existing statutes, laws, and administrative codes. The following example is a brief examination of the impact of the implementation of the federal law on mental health parity on the laws of Florida. The federal Mental Health Parity Act of 1996 required insurers to offer the same benefits for mental disorders and substance abuse as they provide for physical disorders and includes parity for any annual or lifetime limitations and restrictions placed upon such coverage (Levin, Hanson, Coe, & Taylor, 1997). To implement the provisions of the Parity Act in Florida required an examination of its impact on Chapters 394 and 397 and the following state statutes: Alcoholism and drug abuse treatment (§627.669), Child health services (§627.6416, 627.6579), Disability (§627.4233, §627.6561), Disclosure of plan terms (§ 627.6141), Handicapped persons (§§627.644, §627.6576), Mental health (§627.668), and Policies for small employers (§627.6691, §627.6699). Parts of Chapter 394 have a far more extensive legislative history and also are found across s. 2, ch. 71-131; s. 198, ch. 77-147; s. 1, ch. 79-298; s. 4, ch. 82-212; s. 2, ch. 84-285; s. 10, ch. 85-54; s. 1, ch. 91-249; s. 1, ch. 96-169; s. 96, ch. 99-8; s. 36, ch. 2006-227).

Each chapter and section requires review of additional areas based upon structural, organizational, or administrative relationships. Any *single* substantive change would not only need to examined and addressed across every section of every chapter in the statutes, laws, and administrative code but may well require legislation to be

proposed, defended, and passed by the House, the Senate, and the Governor. Since the Commission's charge was to identify all affected existing legislation, the charge itself is problematic within the one-year timeframe of the Commission's operation. This is discussed more fully in Chapter 5.

Method: Discourse as a Window onto Policymaking

Traditionally, policy analysis has framed discourse as analytic, critical, or persuasive. All three perspectives agree that the best way to deal with policy issues is "by analytical improvements in the way we think about our problems" (Schlesinger, 1992) and generally work within an economic model that assumes a set of preferences and works within those preferences to find a solution (White, 1994). As noted in Chapter 1, however, I prefer an alternative to that model.

A discursive approach to policymaking asserts that meaning is socially constructed. I have chosen this approach to examine the processual work of sensemaking, where meaning is always emergent and contested, i.e., generated, imposed, and transformed in social interaction. In his construction of policy theory Fisher (2003, p. 47) asserts that discourse "is grounded in the awareness that language profoundly shapes our view of the socio-political world rather than merely mirroring it … the language of a discourse can never be understood as a fixed or closed set of rules." Further, as Hajer (1993, p. 45) reminds us, "Discourses frame certain problems; that is to say, they distinguish some aspects of a situation rather than others." If discourse is an alternative way to understand political action, then a discursive approach is essential to the understanding of public policymaking.

A discursive approach means embracing the fact that members in policymaking groups have fundamentally different understandings of the problem, the significance of the problem and the range of possible solutions. It allows researchers to identify different and competing policy frames, claims, and accountings. As discourse analyst Karen Tracy (2001, p. 727) notes, "discourse analysis is the study of talk (or text) in context, where research reports use excerpts and their analysis as the central means to make a scholarly argument." Discourse analysis invites inferences from a micro-level to a macro-level through the use of "metatheoretical commentary and methodological elaboration" explicating how talk materials are selected, transcribed, and interpreted (Tracy, 2001, p. 727).

A discursive approach is interpretive. Leeds-Hurwitz (1995) and Sigman (1987, 1995) argue the importance of studying communication as a socially situated activity. Strategic communication is grounded in people's interpretive practices as they attempt to "to exercise control over the understandings others form …, thereby to make different actions and reactions more or less likely" (Sanders, 1987, p. vii).

Studies of institutional talk in Communication are concerned about the precursors and consequences of action. Understanding how discourse links to speakers' interactional goals (Sanders, 1987) is central to a situated, interpretive approach, such as sensemaking from an organizational perspective (Weick, 2001). Cooren (2006) reminds us of the agency of talk and text, as in who or what acts for whom, how he, she, or it acts, and possibly why. "Knowledge" about interaction allows actors to adjust goals and plans based upon the progress of a current interaction (Sanders, 1987). Hence, sensemaking and agency occur in the request for and the creation of accounts. Buttny (1993) describes

calls for accounts and the offering of accounts as transformative discursive practices. This is particularly important with the plurality of values and arguments that emerge when examining a policy issue. Although calls for significant changes in public policy are often seen as transformative change, the question is how do we "see" these actions?

Discourse analysis, "the study of talk (or text) in context" (Tracy, 2001, p. 726), is my preferred theoretical framework and method for analyzing language. Discourse analysis bridges the gap between a macro-analysis of social and institutional structures and the microanalysis of texts and talk that comprise our social worlds. Since this kind of work requires "a level of multidisciplinary sophistication" (van Dijk, 1990, p. 13) that addresses both text and context, discourse analysis situates and elucidates talk through precise and detailed analyses.

Discourse analysis examines properties of language, as well as the patterns of its use, in the context of particular social situations or events (Tracy, 1999). Since policy formulation revolves around the function of language, the words and ideas used by the world of policy may simultaneously describe and define both policy problems and solutions (Rochefort & Cobb, 1994). As a method of inquiry, Fairclough (1992) argues for the systematic textual analysis as part of discourse analysis. Tracy (2001, pp. 726-727) sees the utilization of transcripts and texts "as the central means to make a scholarly argument."

Grounded in the social sciences, discourse analysis also lends itself to the analysis of institutional talk, with a focus on the consequences of the actions that emerged from the talk. Further, discursive methods identify patterns of language use, which assist in

differentiating intended messages, better positioning their causes, and serving as a barometer when interests realign.

Discursive knowledge is part of multiple social, professional, and institutional worlds, which create a relationship of dynamic links within and across these worlds. These chains ensure the continuity of information across community boundaries. I suggest that any theory to examine process must illustrate the motion, the activity, i.e., the dynamics of the complex process known as communication. In fact, more than one theory may be used jointly to create coherence in the understanding of a communication community. This is important in understanding how discourse(s) endures and is transformed over time by the participants in that discourse(s). Weick (1987, p. 97) suggests, "communication is the essence of organization because it creates structures that then affect what else gets said and done and by whom." Although Weick (1995) views sensemaking as a retrospective practice, I suggest that sensemaking is also an "in the moment" practice. Consider that as an event or situation occurs (enactment), participants interpret it in different ways. In order to make sense of the event, participants use a "recipe" comprised of certain properties to make sense of the event: identity construction, retrospection, enactment, socialization, continuation, extracted cues, and plausibility (Weick, 1995, pp. 61-62). Participants use these properties to frame arguments or build bridges to a shared understanding during an event or activity. Hence, sensemaking is about connecting cues and frames to create an account of what is going on "in the moment." To see what is said and done and by whom, to fully understand the process and the structures, requires a discursive approach. As Moore (1995, p. 30) states, discourse is "practice and theory."

Discourse as Practical Theory: Change from the Inside Out

Public policymaking begins with an official acknowledgement of an identified issue or concern. Thus begins a series of practical actions to resolve the issue. From a Communication perspective, practical action "depends on an interpretive understanding of situations and requires deliberation about purposes and moral standards (normative reflection) as well as means (technical rationality)" (Craig & Tracy, 1995, p. 249). Practical theory is considered an alternative to scientific theory, addressing normative ("ought" or ideal) questions that are useful for practical reflection and deliberation. Grounded in empirical description and critique, central to practical action is practical knowledge, which "aims at 'practical truth', that is, at conclusions whose sole purpose is to guide human actions" (Lobkowizc, 1967, p. 36) to a successful resolution.

The term "practical theory" is defined as an observer's description of the problems and technical moves that individuals use to manage these problems within a particular practice (Craig & Tracy, 1995). As a tool, practical theory "informs a grammar of practice that facilitates joining with the grammar of others to explore their unique patterns of action" (Cronen, 2001, p. 26). Grounded practical theory offers tools that facilitate exploration of the unique, situated, patterns of coordinated activity within any group of individuals across a variety of settings and issues.

A grounded practical theory (GPT) addresses a research question at three levels: problem, technical, and philosophical (Craig & Tracy, 1995). The problem level is comprised of typically encountered dilemmas. The technical level is the repertoire of strategies to resolve the problems. The philosophical level contains reasoned principles to govern the use of techniques. Essential tensions in using a grounded practical theory

center on the descriptive –normative (validation criteria), theoretical-applied (practical impact), and positioning-universalizing (political stance). Tracy and Craig (2010) recommend rightsizing the scope of a GPT study through the choice of methodology, site-based and dispersed practices, determining collective human and/or non-human agents, and viewing policies versus practices.

A grounded practical theory study by Tracy and Baratz (1993) parallels my choice to study the Commission. In both studies, talk centers on ideas that were often abstract. Since a number of different opinions are held by members of the group, the talk changes significantly during the course of the event. The institutional affiliations of the participants conferred different levels of status and strongly influence the discursive styles of both speakers and respondents. In both events, there was a formal accounting, "a set of ordered statements" (Shotter, 1993, p. 471): academic articles and a *Final Report*. Finally, the talk was an end in itself in understanding complex settings and processes.

Barge (2004) suggests, "Practical theories are intended to inform patterns of practice that make life better and are judged according to the pragmatic criterion of utility as opposed to an epistemic criterion of truth." Communication and public policymaking are both practical disciplines. Both regard problems as the starting point for research (Craig, 1989, 1992; Lane, 1972). Spoken and written discourse create the *world of policy*. Political discourse is *made visible* within particular discursive (spoken and written) practices (Hajer, 1995; Yanow, 2000). As Tracy and Baratz (1993) remind us, "it is through people's engaging in intellectual conversations (and writing) that ideas are born, get shaped, and die" (p. 301).

Hence, a practical theory accomplishes two things. First, it makes sense of the *process* of a situated event, such as policymaking (Craig, 1989; Lane, 1972). Second, it makes our lives better (Cronen, 1995; Craig, 1995; Craig & Tracy). This comes from a strong applied communication perspective and belief that the work I do can create positive change. Discourse analysis is a practical theory. By using discourse analysis, I am trying to effect policy change from the inside out. Discourse analysis allows me to make sense of the embodied situated actions within the real world of public policymaking. It also gives me the tools I need to understand discourse communities and to respect the centrality of those grammars.

The Florida Commission on Mental Health and Substance Abuse may be best described as a discourse community; it was brought together to perform a specific function and is comprised of individuals from numerous discourse communities, based upon their qualifications or beliefs. Persons involved in the treatment of mental illness are a socio-rhetorical group centered upon a set of ideas, with a common public or abstract goal. In the case of public sector mental health services delivery, the communicative needs of the *goals* tend to predominate in the development and maintenance of its discursive characteristics. In addition, a discourse community has multiple mechanisms of communication among its members, utilizing multiple genres and a specialized vocabulary to further its communicative goals. A discursive approach best allows me to analyze the Commission's stylistic conventions and canonical knowledge to 1) regulate social interaction within and without the group and 2) regulate worldviews by interpreting experience using both talk and text.

I use a discursive approach to explore how an organization and its texts act on behalf of the speaker who has mobilized it (Cooren & Taylor, 1997). It is this process of organization, "a construction of texts generated in communication" (Taylor et al., 1996, p. 222), which is a "complex and continually mediated" activity (Cooren & Taylor, 1997, p. 37). By combining the two perspectives – process and activity – we can examine "how working people communicate, think through problems, forge alliances, and learn as a way of getting work done" (Sachs, 1995, p. 38).

Linnell (1998, p. 143) suggests a discursive approach is the best way to understand work done among three discourse communities: intraprofessional discourse, the discourse within specific communities; interprofessional discourse, the discourse between individuals of different professions at the workplace, at meetings, or in public debate; and professional-lay discourse, when professionals "meet and interact with speak with, or write for, lay people." Considering the complexity to describe the variation in processes and products due to the different roles, attitudes, norms, and identities of stakeholders, I use Gunnarsson's model (1992) to map the discourses of expert and everyday communication. To do this requires an understanding of intermingling of spoken and written discourses as process and as product. The inclusion of Gunnarsson's model allows me to examine communities and genres, it also allows me to extend a discursive analysis to show linkages across and among discourse communities, the use of specialized languages, and the interaction between text and talk across distance and over time.

In the next three chapters, I analyze three types of documents generated during the Commission. Chapter 3, for example, addresses documents that complement a spoken

main event – a meeting, seminar, or conference -- in the form of pre- or post-event documents, such as correspondence, minutes, notices of meetings, transcripts, memoranda, and agenda. Chapter 4 examines documents that have spoken discourse as primary media, in the form of the videotapes of the public meetings of the Commission. Chapter 5 focuses on documents that are formal documentation of the work of the Commission, in the form of its reports and the reports of its workgroups.

In Chapter 3, I use Gunnarsson's model of communicative community and communicative group (1997, 1992) to show 1) the functional and social aspects of the communication of the Commission, 2) the types of communication communities based on criteria related to contact distance (local to distant) and public or private sphere, and 3) the relationship between spoken discourse and written texts. Gunnarsson postulates each group has its preferred medium for different activities, dependent upon type of document, intent, and audience.

Table 2.1 is a simple illustration of the intersection of genre and contact; however, it is more appropriate to conceive of private/public and local/distant as poles on a scale, rather than as distinct cells in a table. Further, these are "superclassifications of different social groupings" (Gunnarsson, 1997, pp. 146, 149), such as groups, organizations, or networks comprised of individuals.

Table 2.1
Gunnarsson's Communication Communities and Communication Genres

Community	Local	Distant
Private	SPEECH writing	SPEECH writing
Public	SPEECH WRITING	SPEECH writing

Gunnarsson (1997) suggests that for each community, its characteristic as local or distant or as public or private, determines the predominant form of communication genre. This is shown by the capitalization of the genre in the table. For example, members of a communication community may choose to communicate among their members primarily through speech to keep a conversation private. However, when communicating with the larger community, writing may be preferred as a way to ensure a consistent message that may be safely replicated and sent to other communities.

I begin with a preliminary coding of the documents generated among the Commission as well as the documents provided to the Commission from external stakeholders. High-level documents are considered more complex documents, such as plans, reports, and pronouncements. These documents generally are granted higher recognition and authority. Middle –level documents are letters, information papers, memoranda, and newsletters, or descriptive and summarizing texts. Finally, lower-level documents are comprised of minutes, lists, acknowledgements, i.e., the more standardized types of text.

In addition to type of document, I also code the document according to why it was written and for whom it was written. This illustrates the "reach" of the writer. A formal report authored by the U.S. Surgeon General, for example, is deemed to have a greater reach than a summary authored by a state commission staff person or a first person account of an individual's struggle with mental illness. I also code who talks to whom. By noting who is in contact with whom, I show the scope of the issues and concerns of individuals and/or of corporate bodies.

I code each document for the types of activity and the medium that is used. The use of multiple media (paper, fax, email, and internet) extends the reach of the many communities involved to the Commission and to each other. After this preliminary coding, I then map the documents using Gunnarsson's matrix of communicative communities: Local-Private, Local-Public, Distant-Private, and Distant-Public. I include the type of community to which each person identifies him or herself: academic, policy, professional, advocate, consumer, and family member. This data then is used to construct an understanding of the communication communities and their genres in the ability of the Commission to achieve its vision through the (un)intended constraints of the talk and texts.

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Example of Coded Transcript

101	Facilitator:	I think that part of that was meant was meant to be addressed in the assessment piece I think but it doesn't say prevention specifically you're right=
102	Chair:	=No, I think that's a really good point, Rod. That prevention just continues to slide sort of slide off off our radar screen [
103	Rodney:	[We react we don't prevent=
104	M1	=Right, we don't prevent we don't pull the babies out of the river but we continue to pull babies out of the river

Parts of my data are extracted from transcripts of the Commission meetings. I code the transcript to represent a number of important features (Table 2.2). First, each

line in the transcript is numbered. This provides the reader and the analyst with a common referential system to compare specific lines of text or to see a given strategy applied to speech events surrounding the selected text. I note identified speakers by name or function, e.g., the facilitator is noted as Facil. Unidentified speakers are noted as speaker. In those cases where the speaker's voice is differentiated by gender, he or she is coded as M1 (male 1), etc.

In addition to identifying *who* talks, discourse markers are noted. Discourse markers denotes strategies, the *how* of talk (see Table 2.3). Discourse markers provide coherence, showing relationships between the different units of talk (e.g., ideas, actions, and turns). They also provide meaning and functions as individuals co-construct definitions or choice of actions. Markers may show segments as description, as explanation, or as narrative. Turn taking is an important component of talk. If each utterance creates a slot for the successive utterance, then timing is important so that each person has the "discursive floor."

When a person has the discursive floor, he or she may be interrupted. This interruption, or simultaneous talk, is most often in the form of overlaps and latched. Overlaps refer to the instances when more than one person speaks at the same time (Sacks, Schegloff, & Jefferson, 1974). Although overlaps appear to be interruptive, they may not be intended or seen as such. In turn-competitive overlaps, for example, one individual is talking and another individual cuts that conversation off. By cutting off the conversation, the second person initiates his or her own conversational turn. This is different from latched talk, which occurs as one individual pauses in his or her turn and another individual picks up the conversational thread. Overlaps and latched talk, for

example, may indicate many things, from enthusiasm, to dominance, to nervousness. Since these actions may be significant, overlapped speech is indicated by a left square bracket ([ ) and latched speech is indicated by an equals sign (=).

Pauses are also discursive strategies and are denoted in the transcript. Pauses are used by speakers to provide time for reflection, to indicate hesitation, or to allow another person to take the discursive floor. Pauses in speech are explained by parentheses enclosing the number of seconds (.5) the speaker paused.

Table 2.3

Transcription Symbols Used in Discourse Analysis

Symbol	Meaning	Example
(.)	(.1) Pause in increments of a fraction of a second	Mike: I think that (.3) it's possible
=	Latched speech (immediately contiguous utterance, whether within a turn or between turns)	Patricia: I don't have a suggestion for what that is, but= LIB =and that's fine
[	Words/phrases spoken at the same time (overlapped)	Caller: It makes me want to [swear Radio host: [Thank you
[---]	Inaudible speech	Marge: As I was saying [---]
[?]	Uncertainty of the preceding word	Emelda: Where's Annaliese [Annaliese?]
ALL	All capitals indicate raised volume in a word or part of a word	Jini: I spent ALL day writing for nothing
(( ))	Double parentheses indicate transcriber's comment	((Several people talking at once))

Other discourse markers include phrases, such as *you know*, *right*, and *what do you think*, to solicit listener affirmation (Schiffrin, 1987). As necessary, when explicating a section or sections of the transcript, these markers are italicized. Underlined words

indicate emphasis by speaker. Double parentheses (( )) indicate additional institutions or individuals previously discussed prior to the selection or explication of a term. Italics draw attention to a particular segment that is the focus of an analytic point.

What My Analysis Looks Like: Familiarizing the Reader

In this section, I provide two data samples. The first sample, Data Excerpt 2.1, is from the correspondence between a stakeholder and the Executive Director of the Committee. The second sample, Data Excerpts 2.2 and 2.3, are excerpts from the November visioning meeting to illustrate how consensus is recognized and built by the facilitator.

Data Excerpt 2.1 provides an example of Gunnarsson's model of local/distant/public/private communities. The excerpt is selected from the correspondence of the Commission's Executive Director, Nancy Bell. The table denotes the form of the discourse (letter), date sent, a synopsis of the content, the type of communication – low, middle, or high; and the type; distant/local and public/private. We see the exchange between Gail Mitchell, self-identified as a mother of a daughter with a serious mental illness, to Nancy Bell, Executive Director of the Commission. Specifically, Gail has written a letter to Nancy, detailing highly personal information regarding the abuses her daughter has suffered in the public mental health system of care in south Florida.

In Data Excerpt 2.1, we see several things from the first receipt and reply (letters 1 and 2). First, the discourse community to which each person self-identifies is established. Gail is a family member. Nancy is part of the Commission. Gail is writing as a mother. Nancy is writing as a person in authority. Second, Gail's correspondence is

middle-level, in that the letter is a summary and a request for assistance. Nancy's response, however, is low-level; she simply acknowledges receipt of the letter and that she will forward the letter to the Commission for review.

Data Excerpt 2.1.

Data coded for Gunnarsson's model

Form	Date	From	To	Content	Level	Type
Letter 1	[no date]	Gail H. Mitchell Family member	Nancy Bell, Executive Director FCMHSA	Explains abuses her daughter suffered in the south Florida mental health system. Asks for the Commission to stop the abuse.	Middle	Distant-Private/ Public
Letter 2	8/8/ 00	Nancy Bell, Executive Director FCMHSA	Gail H. Mitchell Family member	Thanks Gail for letter about daughter's experiences; states most everything wrong with the current mental health and substance abuse system is in her letter; will forward letter to Commissioners and post on website	Low	Distant-Public
Letter 3	8/18 00	Gail H. Mitchell Family member	Nancy Bell, Executive Director FCMHSA	Asks for follow-up to abuses her daughters suffered at specific MH institutions by specific personnel	Middle	Distant-Public
Letter 4	8/24/ 00	Nancy Bell, Executive Director FCMHSA	Gail H. Mitchell Family member	explains purpose of Commission, regrets not able to investigate specific situations, but hopes recommendations and subsequent new legislation will improve the system and correct problems such as those experienced by Gail's family	Low	Distant-Public

In the next exchange (letters 3 and 4), we see a mirroring of the first exchange and level of response. Gail requests action. In this letter, Gail gives a fuller accounting of the abuses her daughter has suffered, with specific claims made against institutions and personnel. The letter is documenting what is wrong with the system from Gail's

perspective. Further, Gail is speaking for her daughter, who cannot speak for herself. Nancy's response, however, begins as a low-level response but invokes a higher-level activity at a policy level as a solution to the daughter's dilemma, in that new legislation will correct the abuses in the system so other adult children do not suffer the same inadequacies in treatment as those suffered by Gail's daughter. However, Nancy's response does not resolve Gail's dilemma to secure the appropriate services for her daughter.

Traditionally, communities based on contact at a distance engage in written communication, hence, these interactions are classed as distant-public. However, I suggest that Gail's letter is simultaneously distant private and public. It is distant private in that she is sharing personal information with Nancy with a request for assistance; however, her letter is to a public body. Further, under Florida's Sunshine Law, Gail's letter is now part of the public record of the Commission's business.

In Data Excerpts 2.2 and 2.3, I use excerpts from the November visioning meeting to illustrate how consensus is recognized and built by the facilitator. The visioning process occurred after the previous day's orientation led by Judge Kathleen Kearney, Secretary of the Department of Children and Families (DCF), on behalf of Governor Bush and the State Legislature about the role of the Commission.

By this point in the Commission meeting, there have been spirited discussions surrounding the phrase "a system that we can't afford is not a system that will work," the terms "expert knowledge," "accountability," and determining expected outcomes of the new system. The latest synopsis of the vision to the group: the system currently doesn't work, our vision is for a system that works for all Floridians, prevents mental illness and

substance abuse, promotes mental health, through coordinated, client-driven, outcomes-focused services. The facilitator (Facil) has just affirmed the Commissioners for bringing up the relationship between the vision and possible institutional impediments and coming to a resolution that it is not their charge. In Data Excerpt 2.2, he acknowledges the unease felt by some members of the Commission, who see a bolder vision as still problematic and who wish to avoid the institutional displeasure of the Legislature.

Data Excerpt 2.2.

November 1999 Commission Meeting

220 Facil: Well, let me do this. I like the direction this is going.

221 I just want to see how you're feeling about these.

First, he stops the conversation "let me do this" (line 220), and reassures them that the visioning process is on track, that the identified legislative "barrier" is an appropriate topic to note; however, his concern is helping the reluctant members of the Commission to move beyond a self-imposed, possibly imaginary constraint. Note in line 221 how he makes a discursive space for a resolution of any remaining unease.

Data Excerpt 2.3.

November 1999 Commission Meeting

232 Facil: and, so, the question I guess the question I want to ask here is, as we look at this and as we think about what you heard last night and this morning, and as you look at the variables on this page in more depth up there, what are your thoughts?

233 do you think that we <u>have</u> the system identified um or there are pieces missing?

In Data Excerpt 2.3, the facilitator readjusts the conversation to allow the Commission to gather their thoughts on the vision, directing them to look at the whiteboard upon which the talking points are posted and diagrammed. Note the use of an inclusive *we* and a plural *you* to engage the Commission as a whole as he searches for individual responses validating or expanding the description of the system. He is more than willing to cede the discursive floor, as he offers options for the Commissioners to review for comment.

In these two excerpts, we see the facilitator, who is an outsider to the *de facto* mental health system, performing many functions. He offers positive reinforcement to the group, switching from the plural to the singular, addressing that *he* is satisfied with the conversation so far and wants to see if the feeling is shared by others in the group (lines 220-221). Later, again using his position as an individual outside the system, he again asks the group about the question *he* needs clarified, that, yes, the system has been identified (lines 232-233).

Summary and Conclusion

Policymaking is a struggle over ideas and values, played out through the strategic use of talk embedded through interaction within multiple social situations: meetings, expert bodies, testimonies, and supporting documents. Numerous individuals bring resources in the form of knowledge to the table. Knowledge or evidence ranges from empirical data to expert witness to public testimony to colleague's opinions. The many types of evidence and their respective claims compete against each other to be incorporated into the decision-making process. Although, evidence may inform, it cannot give the answer.

Since process is as important as product, discourse covers the reading, the writing, and the text that is produced, in concert with the listening, the speaking, and the talk that is produced. Members of a "communication community" share norms, attitudes, and habits related to both forms of communication (Gunnarsson, 1997). Further, the socialization of such a community includes the acquisition of knowledge about and attitudes towards the patterns, functions, and so forth, of *both* spoken and written language. However, it is in these sources and their perceived meaning that we see discourses and points of conflict that reflect different interpretations in the public policymaking process. A discursive approach allows us to have a "close reading" of the talk and text that comprise the public policymaking process and its analyses.

Not only can we determine the links between a policy or change paradigm; we can continue the chain from the discourse that formulates and subsequently implements a policy. In Chapter 3, I examine the communicative chain of text and talk. By this phrase, I mean the way in which agents engage in and create discourses through the inter-action of talk and institutional documents. I examine the interactions among the Commission, its support staff, and the many discursive communities in the public mental health system in Florida, focusing on the Commission's "Mental Health: State of the Science" meeting on 27-28 February 2000.

CHAPTER THREE: THE "COMMUNICATIVE CHAIN": SHOWING HOW TEXT AND TALK ARE LINKED

> Communication is not only functional but also social and is based not only on distant contacts through written texts but also on close contacts through both spoken discourse and written texts (Gunnarsson, 1997, p. 145).

As an organization, a commission is created through routine and ritualized genres of spoken and written communication in which its members engage. The social and functional aspects of communication show how the relationships between its organizational members and external audiences are formed through the use of these genres. The patterns of communication and their relationships among the organizational members and external stakeholders are best characterized as what I hereafter will refer to as a "communicative chain" (after Gunnarsson, 1997, p. 169). A communicative chain shows the intermingling of text and talk (written and spoken discourse) in the communicative process that occurs in everyday activities. Gunnarsson suggests the written and spoken discourses that make up a specific communicative event are so intermingled that it is difficult to determine the borderline between them. Further, she writes that the more complexity involved in an activity, the "longer and more complex the communicative chains" (Gunnarsson, 1997, p. 183).

Because public policymaking is an incredibly complex activity, in any public policymaking process, hundreds if not thousands of hours are spent in talk, from formal discussions to informal discussions over coffee to build consensus, to coordinate all the

work activities of a group, and to manage the "housekeeping" of the organization. Parallel to this talk, hundreds of texts are generated within a commission, from memos to travel documents to minutes to formal reports. The sheer volume of communication generated every month means that a commission member may have time to attend to only some. Further, there may be little time for reflection as the next piece of paper, e-mail, or telephone call demands his or her attention. One determining factor, of which text is chosen to be read, may be the agency of a given text over another, such as a legislative mandate, federal reporting requirement, or an administrative code explaining how a certain procedure must be followed or executed to meet state or federal codes.

Just as human agency is defined as the capacity of a human to act, textual agency is defined as the capacity of texts to do things in specific settings (Cooren, 2004). Consider the following example. A 1999 Office of Program Policy Analysis and Government Accountability (OPPAGA) report recommending specific changes in how the Department of Children and Families (DCF) administer supportive services to children in the juvenile justice system may trump a 1998 DCF performance report given to the Commission by DCF.

A number of questions arise. Who speaks to whom? What is communicated? What tasks are set, and for whom? What talk becomes institutionalised, documented as text? How does one show the relationship between talk and text in complex policy settings? In this chapter, I examine the communicative chain of talk and text that established the Commission and the communicative chain that the Commission itself generated. Using Gunnarsson's (1997) "communication communities" model as my framework, I describe the relationship between talk and text as constitutive not as

dichotomous. I then make visible the invisible chains of spoken and written communication, accounting for the institutional documents (talk and text) the Commission received and generated from its inception through legislative language in Spring 1999 to its February 2000 meeting. I describe who writes what documents and who writes to whom. I provide a close look at the exchange of letters between the Executive Director of the Commission and a mother of an adult daughter with mental illness.

Communication Communities and Communication Genres

Discursive knowledge is part of multiple social, professional, and institutional worlds, which create a communicative chain within and across these worlds. These chains ensure the continuity of information across community boundaries. In this section, I discuss the traditional divide between studies on written and spoken discourse, with the intent of clarifying the concepts of communication communities and communication genres.

Historically, there has been a divide between studies of written and spoken discourse in organizational communication. The study of texts has ranged from the sentence as the highest unit of linguistic analysis (Stubbs, 1983) to the importance of text and the functions of language in context (Firth, 1957; Halliday, 1970; Halliday & Hasan, 1976) to the comparative study of texts in relation to historical or cultural contexts. An early significant publication is by Tottie & Bäcklund (1986). They examined different aspects between speech and writing from grammatical and lexical perspectives in two large corpora, the LOB Corpus and the London-Lund Corpus. Several years later, Biber (1988) elicited a variety of techniques from texts and identified genre variations and

variations between speech and writing. In his study of the London-Lund corpus, he examined face-to-face and telephone conversations, public conversations, debates and interviews; broadcast, spontaneous speeches, and planned speeches; and personal and professional letters. He found that the structure of the text "glues together," i.e., creates cohesion for the reader (Biber, 1988). The reader or listener of the text constructs a coherent representation of the situation described cohesively by the text. Coherence addresses the representational relationships and cohesion addresses the textual strategies by which coherence is built.

Kristeva (1980, p.66) sees texts as constitutive, as always in motion, with the possibility of deconstruction and reconstruction. Bakhtin (1986) focuses on the "life of texts" (p. 114), in that texts talk to each other and that any new text only finds meaning by adding to an existing dialogue. Hence, a text is "of this world," and is many texts. Frow (1990, p. 45) claims, "texts are not structures of presence but traces and tracings of otherness. They are shaped by the repetition and transformation of other textual structures." Likewise, Derrida (1988, pp. 130-131) argues that "there is nothing outside the text"; the iterability of written language gives meaning to speech and conveys meaning and intent. Gunnarsson (1997) describes written discourse as the medium for contact at a distance, both geographical and diachronic. Brown and Duguid (1996, p. 135) suggest, "Society has developed conventions that allow both writers and readers to use the material objects themselves to limit interpretation, to warrant information, and to keep communication relatively simple." Others, such as Collot & Belmore (1996), maintain there is no clear grammatical distinction between spoken and written forms of discourse.

Within the study of text, however, much of the analyses focused upon the text as a product, not as a process. The same can be said of the study of spoken communication. The container-content metaphor of communication was a dominant model for many years (Shannon, 1948), e.g., the container is the organization and the content is communication. Reddy (1979) describes the major failure of the conduit metaphor is that it objectifies meaning and influences people to talk and think about mental content as if it possessed an external, inter-subjective reality (Reddy, 1979). There is another perspective. Spoken communication is associated with a specific event, time, place, participants, purpose, and history; hence, it is a "situated, circumstanced interaction" (Taylor, 1999, p. 25).

Spoken communication requires its participants to engage in basic procedural rules -- that is, turn-taking or interaction - in order to produce conversation as an orderly, situated accomplishment (Sacks, Schlegoff, & Jefferson, 1974). Further, each participant brings to the floor his or her own linguistic repertoire of textual elements (e.g., words, phrases, metaphors, etc. that came from the formal study of language). This repertoire is a resource for the production of talk. Whether one sees the actual text of the talk as a documentation of an accounting (Garfinkel, 1967) or the talk as a way to continue the authority (iterativity) of a text (Derrida, 1988), seeing talk and text as dichotomous limits the possibility of making sense of interaction(s) that encompasses both text and talk.

The Processes of Policymaking as Organizational Communication

A number of researchers understand communication as the intersection of conversation and text (Austin, 1962; Greimas, 1987; Gunnarsson, 1992, 1997; Labov & Fanshel, 1977; Taylor, 1999; Taylor, Cooren, Giroux, & Robichaud, 1996). Taylor et al. (1996, p. 222) frame an organization as a noun but suggest it also should be

conceptualized as a text. Cooren and Taylor (1997) assert organization emerges through discourse, as "the words of the repertoire thus record, in other words, as well as inform the practices of the organizational communication" (Taylor, 1999, p. 55). Although Cooren and Taylor (1997) argue that it is the text that acts on behalf of the speaker who has mobilized it, the challenge, as they see it, is to demonstrate how something, which occurs in conversation, provides support to the organization. Gunnarsson (1997) contends that the processes of organizational communication are shown in its written and spoken discourses and can be examined by different perspectives of the work.

Sachs (1995) argues for the existence of process- and activity-oriented perspectives within an organization. A process-oriented perspective represents the organization as "sets of defined tasks and operations such as those described in methods and procedures, which fulfill a set of business functions (the work-flow approach reflects this)" (Sachs, 1995, p. 36). The activity-oriented perspective "suggests that the range of activities, communication practices, relationships, and coordination it takes to accomplish business functions is complex and continually mediated by workers and managers alike" (Sachs, p. 37). By combining the two perspectives – process and activity – we can examine "how working people communicate, think through problems, forge alliances, and learn as a way of getting work done" (Sachs, 1995, p. 38).

In his revolutionary text, Austin (1962) observed that we "do" things with words. Language does not merely state facts or describe a state of affairs; language *is* action. If language generates action, then it is possible to say that agency is discursive. Agent has long been synonymous with the term actor (Giddens, 1984). After all, it is the constituent individuals or communities within a relationship that are "re-presented" in the discourses

of the communicative interaction. Cooren (2004), however, defines an "agent" as "that which acts." Not only do humans act as agents, but human agents generate discursive agents, such as institutional texts. In Cooren's view, texts may not only act by themselves, but also act for others, and sometimes in lieu of others.

There are many examples of texts acting as institutional agents. A memo may inform us of a supervisor's decision on a process or procedure. The memo acts for the supervisor in relaying information to the employee to act. A piece of legislation assigns acts of responsibilities to a specific group to implement and account for specific acts. The language used to direct individuals or organizations by these texts displays intention. Robichaud (2006, p. 114) writes that intentions are

> properties of institutionalized nets of practices emerging out of the conversations in which we constantly redefine our connections to others, machines, nature, and texts.

Robichaud's notion of "institutionalized nets of practices" corresponds to Gunnarsson's construct of communication communities. Gunnarsson (1997) suggests spoken and written communications are an integral organizational process shown by the interactions between the individuals comprising the organization and the individuals outside of the organization. Members of a "communication community" share norms, attitudes, and habits related to both forms of communication (Gunnarsson, 1997). Further, the socialization of such a community includes the acquisition of knowledge about and attitudes towards the patterns, functions, and so forth of *both* spoken and written language. This background, or procedural knowledge, allows its users to

communicate effectively with each other and to reproduce a community's "norms, epistemology, ideology, and social ontology" (Berkenkotter & Huckin, 1995, p. 501).

The construct of a communication community or communicative group addresses expert and everyday communication and stresses process as well as product (Gunnarsson, 1997). Process produces actions. Actions constitute products. Products are often texts, which "act" and account. Which communication genre is used is dependent upon a number of factors. Spoken discourse, for example, has greater immediacy in its use with local audiences. Written discourse, created for audiences at geographic and diachronic distances, is more standardized discourse, based on a community's preferred patterns of writing. Examples include the use of passive voice and nominalization in scientific texts and the use of "person-first" language in advocacy and consumer texts. With the advent of the internet, spoken discourse is available to distant communities through streaming technologies and written discourse is available immediately through social media and electronic mail.

As communities engage in talk and texts among themselves, they interact with other individuals and communities, eliciting responses to the original author(s), and initiating novel talk and texts. This continuous and ongoing activity allows us to see the inter-action that maintain and further a discourse. Not only can we determine the links between a policy or change paradigm, we can connect these links together to create a chain of previous, current, and future discourses. Hence, the use of textual agents by human agents is significant in understanding this communicative chain of text and talk. One way of determining this chain is through praxis, or the work involved in the activities necessary to support an organization.

Establishing the Commission: The Life of House Bill 2003

Before the Commission could begin its work, it had to be created. In this section, I present what I see as the first link of the communicative chain that became the Commission. I review the spoken and written discourses that occurred as an issue first is problematized, and then begins its life in the State of Florida's House of Representatives.

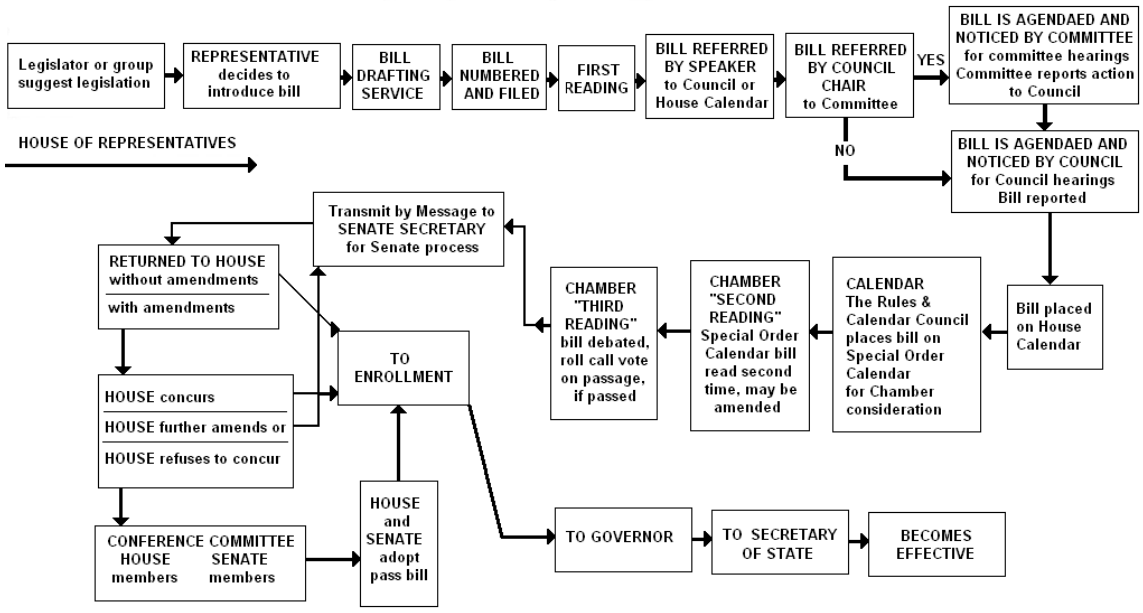


Figure 3.1. How a Bill Becomes Law

In 1999, there was a conversation that led to Representative Sandra Murman (R-Tampa) and the House Committee on Children and Families to file a bill that would create a commission to study the public mental health services system in Florida. After Representative Murman introduced the bill, it took on a life of its own. Figure 3.1 illustrates a bill's trajectory through the House of Representatives. The bill went to the Bill Drafting Service. The Service wrote the bill and reviewed it for appropriate style and format.

Data Excerpt 3.1

Section 4 of HB 2003

1 Section 4. The Department of Children and Family
2 Services is directed to propose statutory revisions to part IV
3 of chapter 394, Florida Statutes, pertaining to the overall
4 financing and contracting structure for publicly funded mental
5 health and substance abuse services. Other areas to be
6 reviewed for this statutory proposal are: priority population
7 groups for publicly funded mental health and substance abuse
8 services; a description of the comprehensive mental health and
9 substance abuse delivery systems; district mental health and
10 substance abuse needs assessment and planning activities; and
11 local government responsibilities for funding mental health
12 and substance abuse services. The department must convene a
13 workgroup to assist them in the development of these statutory
14 revisions. At a minimum, this workgroup must include two
15 persons who have knowledge and interest in mental health and
16 substance abuse services. The proposed statutory revisions
17 must be submitted to the Office of the Governor, the President
18 of the Senate, and the Speaker of the House of Representatives
19 no later than December 1, 1999, for consideration by the
20 Legislature in 2000. (HB 2003, Original filing, 1999, p. 5)

HB 2003, as it was originally filed, was twenty-three pages long, with 13 sections relating to mental health and substance abuse services. Section 4 is the relevant section of the bill for the purposes of this chapter, as noted in the original filing in Data Excerpt 3.1. In addition to the bill as proposed, there is a House Summary of the bill, shown in Data Excerpt 3.2, showing the extent of HB 2003 as originally filed.

The bill was assigned a number and filed as HB 2003. Once filed, HB 2003 was published in the House *Journal*, where it was given its "first reading." The "first reading" is the official notification to the House of Representative of the inception of HB 2003. Representatives read the bill and summary and begin informal conversations around its scope and content. The House *Journal* is the authoritative record of actions taken by the House and its committees. It includes the titles of bills introduced, the full text of amendments considered, titles of bills passed, and a breakdown of how each

Representative voted on matters taken up during floor sessions. Note that the *Journal* is a formal accounting of the steps taken when a law is passed. As an institutional text, it has agency to speak of the House's actions in a court of law or to the Executive and Legislative branches of Florida state government.

Data Excerpt 3.2.

House Summary of HB 2003

> Authorizes the Department of Children and Family Services to use unit cost methods of payment for mental health and substance abuse services. Requires the department to establish certain contract, payments, and accounting standards. Directs the department to convene a workgroup to develop statutory revisions relating to community alcohol, drug abuse, and mental health services. Requires a report to the Governor and Legislature by December 1, 1999. Provides requirements for a substance abuse services quality assurance program. Provides for district quality assurance coordinators if specific appropriation is required. Provides for establishment of a children's substance abuse services system to provide prevention, intervention, and treatment services to children at risk for substance abuse and children with substance abuse problems. Requires each departmental service district to implement a comprehensive districtwide children's substance abuse information and referral network by July 1, 2000. Provides for integration of treatment and sanctions. Provides for the 4-year operation of Children's Network of Care Demonstration Models in which state and local agencies collaborate to deliver substance abuse services to local target populations through locally organized networks of care. Provides for purchase of services and provides criteria for operation of the demonstration models. Establishes a program for award of school substance abuse prevention partnership grants to be administered by the department in cooperation with the Departments of Education and Juvenile Justice. Provides grant application procedures, and requirements for funding and operation of programs awarded grants. Directs the department to develop a publicly available substance abuse prevention Internet website. Directs the department to establish a program to provide drug-free communities support match grants, if specific appropriations are provided. See bill for details.
>
> (HB 2003, Original filing, 1999, p. 23).

After publication in the *Journal,* HB 2003 received a review by the Speaker of the House. Because of its complexity, HB 2003 was referred to the House Council for review by two committees: the Committee on Governmental Operations and the Committee on Health & Human Services Appropriations. HB 2003 was then "agendaed" and "noticed" by both Committees. "Agendaed" is the listing of the bill on the house agenda. "Noticed" means the bill will be discussed by the Committee. Prior to being

"noticed," a report on the projected impact of the bill may be requested. After the merits of the bill are debated, the bill receives a decision about its status. The decision is reported to the Council. The bill again is "agendaed" and "noticed." If it receives a favorable decision, the bill advances. If not, the bill is "killed" and no further action is taken.

HB 2003, as approved, then moved to the Rules and Calendar Council and onward to the Chamber. Once it moved to the Special Order Calendar, HB 2003 received its second and third readings. During the second reading, the bill may be amended. An amended bill is an engrossed bill. A bill may be engrossed many times during its move through the various Committees and Councils. The amendment process occurs in session and outside of session, as versions are passed among Representatives for review and discussed. HB 2003 was engrossed two times. In its first engrossment, Section 4 transformed from a half-page with 20 lines of text with no title that began with an action by the Department of Children and Families to 5 pages with 147 lines of text entitled "Commission on Mental Health and Substance Abuse" followed by an official finding of Legislature (HB 2003, First Engrossed, 1999, pp. 5-9). In its second engrossment, Section 4 was not amended and remained in the form of the first engrossment (HB 2003, Second Engrossed, 1999, pp. 6-10).

In the third reading, HB 2003 was debated formally and a roll call vote was taken for passage. HB 2003 was passed and moved on to the Senate. A message was sent to the Senate Secretary to start the Senate process. After review by the Senate, the bill returned to the House. After concurrence by the House, HB 2003 was sent to the Conference Committee of House and Senate members renamed as a "conference report."

HB 2003, as a conference report, was adopted in its entirety by a majority of the House and Senate Conference Committee. HB 2003 then was "enrolled." An enrolled bill has passed both houses of the legislature in identical form. HB 2003 was then converted into an act for presentation to the Governor. The Governor may sign the Act, let it become law without signing, or veto the law. HB 2003 as an Act was signed by the Governor. Delivered to the Secretary of State, it became effective sixty days after adjournment of the Legislature.

Consider the complexity of the actions involved in creating the possibility of the Commission. There are twenty-one steps in Figure 3.1, which is a greatly simplified version of the many hands and voices that touched HB 2003. Notice also the need for accounting, i.e., the *Journal* that requires official daily texts to be written, promulgated, and archived to document the activities necessary to create a bill to address a single issue.

Note how both nominalization and agency become elements of the text as I describe the trajectory of HB 2003 using the language of the political process. Instead of the House placing the bill on the agenda, the bill is "agendaed." Instead of the House discussing the bill, the bill is "noticed." The House of Representatives as the actor acting on the bill is missing. The bill is now performing actions. The bill "goes"; it "advances." It is acted upon when it is "killed." Later in the process, the House and the Senate concur or amend or adopt. Here it is the institution acting. However, unless one reads the House or Senate *Journal,* the vote, that is, the accounting of individual actions on a bill, is unknown. This shows that the visible is invisible to people who are unaware of the many steps in and paths to the policymaking process and the accounting of that process.

By means of a process of nominalization, inanimate objects are animated, removing speakers from the actual interaction. Responsibility for the process is removed from human agents. Where is Representative Murman as a driver of the process? The text itself appears to commit actions, making the text more difficult to read. By infusing agency into the bill and its "actions," it is seen as the agent driving the process. The others mentioned in the description are there merely to assist the bill.

Note the specialized vocabulary of the legislative process: e.g., *first, second, and third "readings," agendaed, engrossed*, and *enrolled*. Each step of the process generates a text, whether it is in a version of a bill, a notice of advancement, a decision to accept a text as is or to revise, a formal accounting of a vote, or a signature to establish a law. Accompanying each text is talk, whether it is to define an activity, to expand the text, to argue for required membership on a commission, or to persuade others of the importance of the bill. From a simple 4-line summary of 21 lines of text, the filing morphed to a five-page list of tasks, membership, accountability, and deliverables. By tracking the text, it is possible to examine how the spoken and written discourses in the 1999 legislative session were codified in HB 2003, as enrolled and institutionalized in the Florida Statutes.

HB 2003 identified an area of concern, a public policy problem: the current mental health and substance abuse service system in Florida was outdated. It offered a solution: a systematic review of the system and recommendations to bring the system to current best practice. It established a body to perform this action -- the Commission.

The Commission as Talk-in-Interaction

In this section, I describe the coding of the available Commission documents from its Orientation meeting in November 1999 to its February 2000 "Mental Health: The State of the Science" meeting. I provide a definition of the Commission and an overview of its spoken and written discourse.

When looking at who "talks" to whom, we need to first define the communities involved. Communication constitutes an essential element in the activities of a group. The internal structure of a group, such as the Commission, and its relationship to external groups influence communication at every level. Gunnarsson (1997) reminds us that the social structure of the group influences the outcome of communication.

Twenty-eight individuals comprised the organization known as the Commission. Twenty-three of the twenty-eight were appointed by the Executive and Legislative branches of Florida state government as the *de jure* members, that is, members as defined by HB 2003. The twenty-three Commissioners were mental health and substance abuse providers, hospital administrators, employers, insurance carriers, family members, and consumers of public services. The Chair of the Commission, one of the twenty-three designated members, was the Dean of the University of South Florida's Florida Mental Health Institute (FMHI) and a former public sector administrator for mental health. The twenty-fourth member of the Commission was its Executive Director, an administrative position mandated by HB 2003.

The Executive Director had a working staff comprised of three staff members of the Florida Mental Health Institute. The Executive Director was responsible for the administration of the Commission. The three staff members were responsible for note-

taking, processing documents given to the Commissioners by external stakeholders and speakers, posting Commission agendas on the web, and coordinating a three-person video crew, who were FMHI staff. The final member was the facilitator, a professor of Communication at the University of South Florida. His role was to bridge the communicative communities within the Commission and to engender fruitful discussion. The working staff and the facilitator, for the purposes of this chapter, also comprise the "working" Commission.

Of the many documents available, I first grouped materials into the two genre groupings used by Gunnarsson: spoken and written discourse. I then re-sorted the documents into three categories. The first category is comprised of texts that complement a spoken main event, such as a meeting, seminar, or conferences in the form of pre- or post-event texts. The second category is texts that have spoken discourse as primary media, i.e., the videos of the Commission meetings. The third category is comprised of those texts that formally document the work of the Commission. These three categories were subdivided into 16 sub-categories. Twelve sub-categories comprise written discourse and four sub-categories comprise spoken discourse.

I found two additional categories were necessary to complete the chain: informal talk and tasks. In any communicative group, there is informal talk that occurs, whether as speech or as an email, to request the performance of tasks, to provide an accounting of work to be performed, or as a reminder. It is the housekeeping or operational talk that contributes to activities being completed, tasks being assigned, and work being finalized. Some of the informal talk and the prospective or resultant tasks can be documented in emails, legislation, and other documents. Although the actual documentation for all of

the talk is unavailable, I draw upon Gunnarsson's (1997, p. 170) description of the collaborative nature of writing, in that colleagues

> write together with colleagues; write by oneself, but discuss expressions, etc., with colleagues; ask colleagues to read and comment on texts; and write by oneself without consulting anyone" to support the additional categories of actions.

Of the 521 documents produced by the Commission that were available for coding, 49% fall into Category 1, 28% fall into Category 2 (spoken discourse), and 23% fall into Category 3 (written discourse). I disagree with the view that the role of spoken discourse in the production of texts does not necessarily "say anything about the communicative process in which they are embedded" (Gunnarsson, 1997, p. 164). Gunnarsson used a social network analysis approach in her study; I use a discursive approach. The interim and final reports of the Commission are clearly intertwined with the spoken events of the Meetings, such as the invited experts and the public testimony. Notwithstanding, the spoken discourse by the consumer and family member communities is not reflected as it was intended to be in the final text. That intention is found only in the transcripts. In one communicative process, the spoken discourse is paramount; in another, it is re-entextualized. Hence, if we examine all of the communicative processes involved in the activities of the Commission from July 1999 to February 2000, we see that the individual activities clearly demonstrate the communicative chain of text and talk.

Table 3.1 shows the matrix of the types of talk that occurred up until and surrounding the meetings. Although we cannot see all of the talk or all of the texts that occurred during the 16 November 1999 meeting and the 27-28 February meeting of the Commission, we can see a considerable amount of interactions among the numerous stakeholders. Stakeholders include the Commission members, the administrative staff, and additional communication communities: mental health professionals, state government, consumers and family members, state agency staff, and other professional and lay communities involved in the larger mental health community.

I coded 521 spoken and written tokens of discourse generated by the Commission or given to the Commission by its stakeholder groups (Table 3.1). Within the types of written discourse tokens, I suggest several distinctions. For example, all the Commission members received electronic or paper copies of the minutes (MIN), content notes (CON), agenda (AGE), presentations (PRE), ephemera (EPH), legislation (LEG), and press releases (PRS). They also received copies of all the reports (REP) and the draft report (DRA). However, the minutes (MIN), content notes (CON), and agenda (AGE) were created by Commission staff, forwarded to the Executive Director and the Chair of the Commission for approval, and then sent out by the Executive Director to the members with a cc (carbon copy) to staff.

Most Commission members were part of the monthly Commission meetings [COM], which meant they were also recipients or participants in the discourses of the meetings. The invited experts [EXP] all spoke and engaged in a question and answer forum with the twenty-three Commissioners. Commission staff entextualized this talk into accountings found in the business meeting minutes [MIN] and the content notes

[CON]. Public testimony [TES] was summarized and entextualized into the minutes and content notes by Commission staff. The spoken discourse was captured in videotapes [VID] and posted on the internet as a public accounting with the written discourse of agendas [AGE], meeting minutes [MIN], content notes [CON], and PowerPoint presentations [PRE].

Table 3.1.
Matrix of the Types of Talk of the Commission

Written discourse (rectangles)			Spoken Discourse (hexagons)		
#	Type	Acronym	#	Type	Acronym
78	Letters	LET	4	Commission meeting	COM
4	Minutes	MIN	24	Invited Expert	EXP
4	Content notes	CON	86	Public Testimony	TES
4	Agenda	AGE		Videos (hrs)	VID
50	Report	REP			
1	Drafts	DRA			
1	Legislation	LEG	Additional Actions		
9	Presentations	PRE	Unknown	Informal talk (housekeeping/operational)	TAL
62	Ephemera	EPH	Unknown	Tasks	TAS
12	Press Releases	PRS			
10	Budget/Financial	BUD			
172	Email	EMA			

It is impossible to account for every piece of text and talk that occurs in the public policymaking process. It is simply overwhelming. Even this selective accounting of available documents gives me pause. However, there is another way to examine the communicative chain of written and spoken discourse. If we examine the available

documents as a whole based upon each meeting, we can see how talk and text happens and how they create events.

Charting the November 1999 to February 2000 Meetings

In this section, I show what happened after the enrollment of HB 2003. Using the available documents, I reconstruct the communicative chain of text and talk. To do so, I use a combination of text and graphical flowcharts. After HB 2003 became law, the Commission was established. Established in law, it had a name, an institutional "home," a charge, deliverables, and a list of the types of people who were to comprise it. However, it existed only as an amorphous *de jure* (legal) entity.

In Figure 3.2, the large circle in the middle denotes the entity known as the Commission [COM]. The grouping of figures on the left side of [COM] is the activity that occurred in the Executive and Legislative branches and in the state Department of Children and Families. The figures on the right side indicate the communication communities and individuals who were contacted to serve. The black hexagon denoting talk [TAL] denotes the institutional talk that occurred. The white hexagon [TAL] denotes the individual talk that occurred.

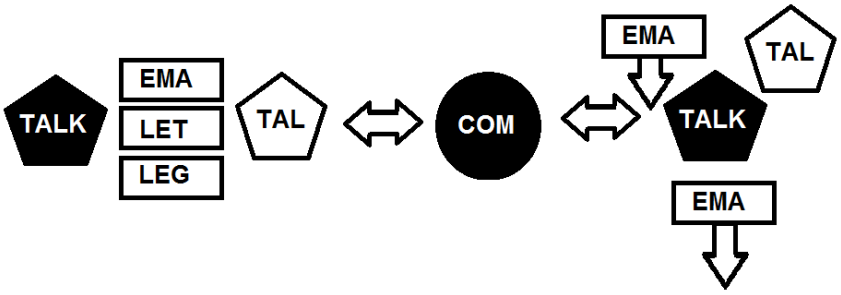
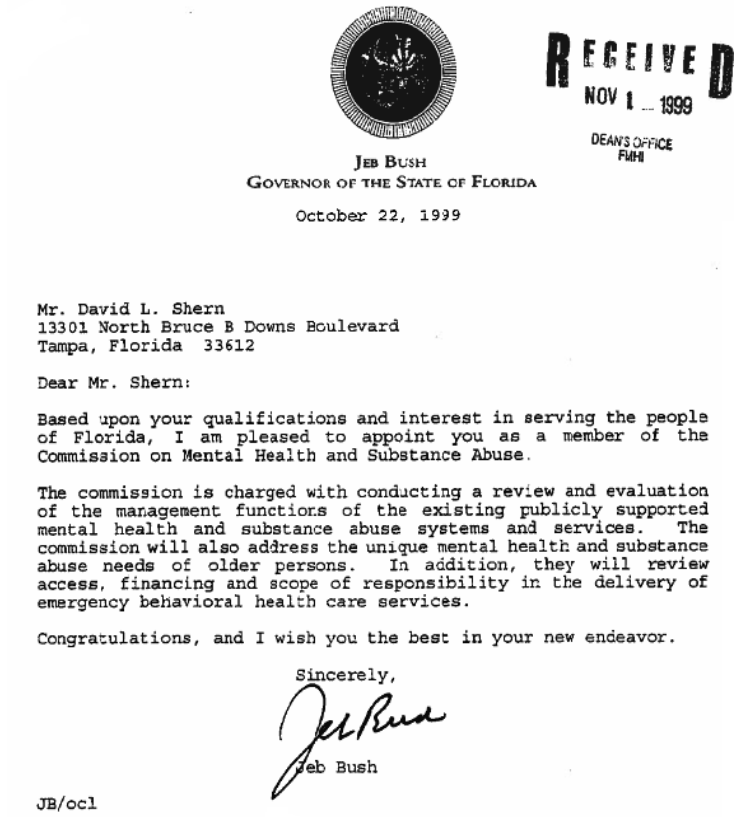


Figure 3.2. Activities to Establish the Commission

The work conducted between the enactment of HB 2003 and the November orientation of the Commission can be seen as work done on behalf of an incorporeal body. Work was conducted in its name; however, there was no Commission *per se* to perform these tasks. Hence, it would be the Governor and his staff, acting on behalf of the legislated body, who continued the Commission's communicative chain of text and talk. After deliberation as to the individuals who would serve, the Governor instructed administrative staff to send letters [LET] to the proposed members. Note the "JB/ocl" in the lower left-hand corner in Excerpt 3.3. The "JB" indicates the letter was dictated by Governor Bush and the "ocl" indicates the initials of the staff person who sent out the letters.

Data Excerpt 3.3.

Letter from Governor Jeb Bush to David Shern, October 22, 1999



RECEIVED
NOV 1 1999
DEAN'S OFFICE
FMHI

JEB BUSH
GOVERNOR OF THE STATE OF FLORIDA

October 22, 1999

Mr. David L. Shern
13301 North Bruce B Downs Boulevard
Tampa, Florida 33612

Dear Mr. Shern:

Based upon your qualifications and interest in serving the people of Florida, I am pleased to appoint you as a member of the Commission on Mental Health and Substance Abuse.

The commission is charged with conducting a review and evaluation of the management functions of the existing publicly supported mental health and substance abuse systems and services. The commission will also address the unique mental health and substance abuse needs of older persons. In addition, they will review access, financing and scope of responsibility in the delivery of emergency behavioral health care services.

Congratulations, and I wish you the best in your new endeavor.

Sincerely,

Jeb Bush

JB/ocl

Upon receipt of these letters, which were delivered via email [EMA] and by post [LET], additional talk was generated that resulted in the acknowledgement and agreement of the recipients to serve on the Commission. This then generated additional talk and a series of emails among the Commission members and the DCF administrative staff to set up the orientation meeting. This would involve the coordination of travel, lodging, and meals for thirty persons, who would be attending the meeting. It would also require texts to be gathered and copied for the orientation packets.

The November Meeting: The Commission Orientation

The Commission Orientation was the major focus of the November meeting. The data for this part of the discussion comes from the Minutes of the November 16, 1999 meeting. Figure 3.3 illustrates the talk and the text that were provided to the Commissioners at this meeting.

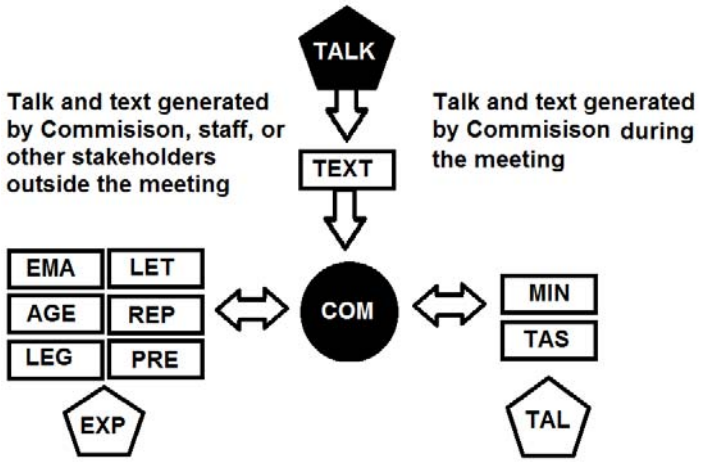


Figure 3.3. Schematic of Talk and Text of the November 1999 Meeting

The black hexagon [TAL] in the first row represents the official and administrative talk discussed above. The hexagon [COM] in the center represents the Commission. To the

left of the [COM] are five rectangles, representing text: agenda [AGE], reports [REP], legislation [LEG], letters [LET], and presentations [PRE]. The hexagonal box [EXP] represents invited experts. Note that the enabling legislation [LEG] was formally on the agenda for discussion. HB 2003 as enrolled placed the Commission's "home" within state government (the Department of Children and Families). The importance of the meeting can be seen in the involvement of the Executive and Legislative branches of the government. The Governor sent a representative. Assistant Secretaries of State, an Assistant Director, and Legal Counsel also gave presentations and spoke with members.

In public policymaking, experts are often consulted, thus laying the groundwork for the activity to come. Interprofessional discourse between individuals or representatives from different professions (Linnell, 1998) established the tenor of the orientation. Professional credentials establish expert and authority. Judge Kathleen Kearney, Secretary of the Department of Children and Families (DCF) opened the session, welcoming the Commissioners on behalf of the Governor and introducing the agenda for the meeting. Five formal presentations [PRE] were made at this meeting. John Bryant, DCF Assistant Secretary, opened the meeting, with a presentation on House Bill 2003 and the Governor's expectations of the Commission. He also conducted a second presentation, which was the overview of the Mental Health Program Office. Ken DeCerchio, Assistant Secretary for Substance Abuse, gave an overview of the Substance Abuse Program Office. Bob Sharpe, Assistant Deputy Director of Medicaid, gave an overview of the Agency for Health Care Administration and Medicaid financing, and John Slye, legal counsel for the Department of Children and Families, on the ethical obligations of the Commission. In addition, Commissioners received several texts in a

packet of information, including a copy of House Bill 2003 [LEG], DCF organizational charts [REP], copies of the presentations [PRE], a letter from the Governor thanking the Commissioners [LET], and a copy of the ethical guidelines [LEG].

During and between presentations, the Commission members asked questions for clarification or to provide feedback upon the information provided to them (personal communication with David Shern). The business meeting minutes [MIN] report, "At this time each commission member shared his or her vision for the Commission" (Florida Commission on Mental Health and Substance Abuse, 1999, November 16, p. 2). However, no particulars were noted.

In Figure 3.3, moving to the right of the Commission [COM], we see the beginning actions of the Commission as it [COM] generated talk [TAL] and tasks [TAS]. Consider the tasks that were accomplished. A personnel committee [TAS] was formed to hire an Executive Director, a task required by HB 2003 [LEG]. Names for an Advisory Committee were solicited, with the proviso that a consumer of mental health services be added to the Committee. It was also at this meeting a Chair was elected [TAS] and a facilitator was suggested to assist in creating a "roadmap" for the Commission, [TAS]. Another instance of expert was invoked, with the suggestion that the Commission invite someone to speak to them regarding the newly released Surgeon General's report on mental health [TAS]. Note that professional credentials establish expert and authority; both of these were in evidence at the orientation. In the morning meeting, Secretary Bryant introduced David Shern and announced that Dr. Shern would serve as interim chair until a Chair was elected by the Commissioners. That afternoon, Dr. Shern was elected as Chair.

At this meeting, the business meeting notes were taken by a DCF staff person. E-mail was deemed the most efficient way to address the geographical distances among Commission members. The spoken discourse of the meeting was entextualized in the meeting minutes. This accounting of the Commission's orientation establishes the activity and the roles of the players. It clearly indicates the important role DCF has as the administrative "home" of the Commission and as the oversight agency for the Commission's tasks. Less visible is DCF's role as the institution to be most affected by changes to the mental health and substance abuse delivery system.

Of the many tasks that were generated, in this chapter, the subsequent sections will track the larger "meeting" tasks as well as a single specific task embedded in the language of HB 2003: that of the inclusion of the consumer voice. In the November meeting, there was a family member present, Diane Steele, who is also a Commissioner, and a member of the audience who asked if consumers could be added to the advisory committee (November 1999 meeting minutes, p. 2). The Commission agreed to add a consumer of mental health services to the Advisory Committee. The business meeting notes reflect these activities.

Preparing for the December Meeting

In Figure 3.4, we are now in the period of preparation for the December meeting. Between 16 November and 13 December, there are numerous housekeeping, operational, and informational tasks [TAS] that must be completed. Conversations occurred between DCF and the Commission members. DCF staff sent the minutes of the meeting to the Commissioners [EMA] and the other participants. The Executive Director and three administrative staff are hired [TAS] and, along with Chair David Shern, are housed at the

Louis de la Parte Florida Mental Health Institute, which is represented by the black rectangle entitled [ADM].

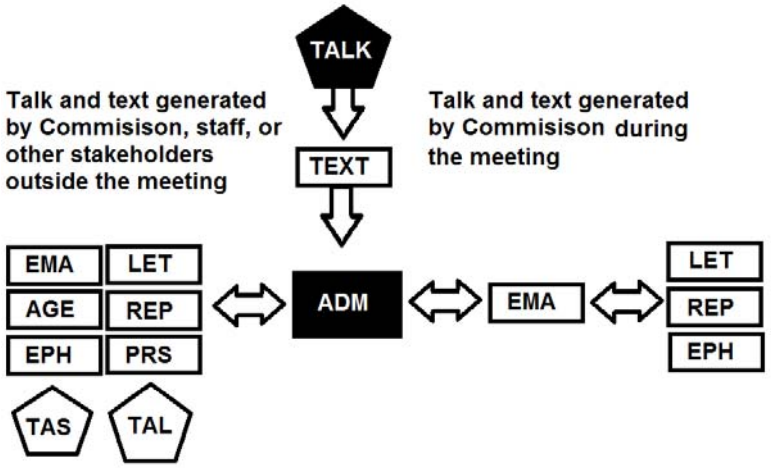


Figure 3.4 Schematic of Talk and Text Preparing for the December 1999 Meeting

To the left of [ADM] are internal Commission activities. Commission staff created press releases [PRS], housed reports [REP] and ephemera [EPH], and generated letters [LET] and email [EMA] answering questions, resolving travel, and following through on assignments. In addition, staff attended to the administration of the Commission, including budgets and travel plans [BUD], and the identification of experts [TAS].

Discussions [TAL] were held on how best to disseminate information about the Commission and its work. The decision was made to create a website [TAS]. Not only would it provide a public place to post notices of the Commission meetings, which would be held across the state, it would provide an electronic archive of its agenda, meetings, and speakers. In addition, the business meetings of the Commission would be videotaped [TAS] and placed on the web for public feedback and discussion [TAS]. An automatic

email application would allow emails to be sent to the Executive Director and to the administrative staff for response.

To the right of [ADM] are the talk and text generated to and by Commissioners and stakeholders outside of the Commission. This includes emails [EMA] sent to and from the Commissioners regarding travel and venue of the next meeting, review of the November minutes [MIN], and other materials regarding operations deemed important to share across the Commission from its staff and from DCF [REP] [LET] [EPH]. As the December meeting time came closer, we see additional emails [EMA], reports [REP], and letters [LET) sent to the Commissioners [COM] by the Executive Director and the Commission Chair.

Chaining the Text and Talk at the December Meeting

The data for this section is from the December Business Meeting Minutes and the Content Notes, as well as the Commission Archive. The December meeting was the first official Commission meeting, and, in many ways, established institutional norms and structures for the Commission. Each subsequent meeting would focus on a single agenda issue, which would include expert and public testimony. Each meeting was divided into two sections. In the morning, the Commission would conduct its business meeting and invite speakers to address the agenda [AGE]. In the afternoon, the Commission would hear public testimony [TES] from external stakeholders, followed by a brief closing meeting of the Commission. The facilitator, Eric Eisenberg, conducted his first discussion [TAL].

Figure 3.5 represents the talk and the text that occurred in the December meeting. Similar to the November meeting, the symbols on the left side of the Commission [COM]

shows the talk and the text that were generated by the Commission staff or received by the staff to give to the Commission. The symbols on the right side of the [COM] show the content generated by the Commission.

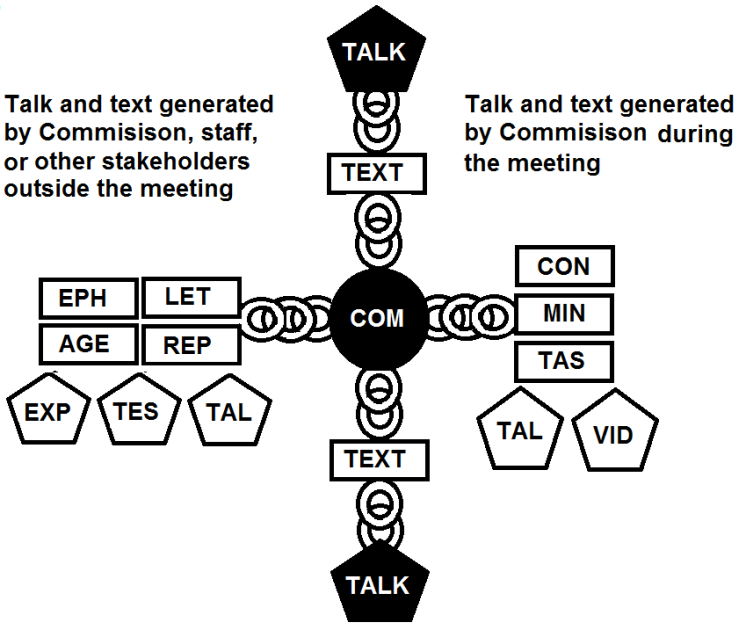


Figure 3.5. Schematic of Talk and Text of the December 1999 Meeting

The business meeting minutes [MIN] account for actions taken by the Commission and/or its members and well as future actions. In some cases, actions had already started prior to the request of the Commission. The December business meeting minutes reflect the wish of the Commission to establish a webpage or bulletin board site [TAS]; however, the website was already under construction.

During the December meeting, [MIN], new text and talk were added to the business meeting: content notes [CON] and video [VID]. Content notes provide a thicker description of the Commission meeting than the business meeting minutes [MIN]. The content notes [CON] summarize the presentation [PRE] on interaction of the legal and mental health and substance abuse systems given by John Petrila, chair of FMHI's

Department of Mental Health Law and Policy, the invited testimony [EXP] from stakeholders deemed as expert who spoke at the morning meeting, and the public testimony [TES] of stakeholders who came and waited for the opportunity to present.

Note, however, that the content notes [CON] and the videos [VID] do not provide a one-to-one match of content. As with any entextualization, some elements are selected and others discarded. The content notes [CON] describe the facilitated exercise as to what a perfect Florida MHSA (mental health and substance abuse) system would look like. Only four individual responses were noted, although on the videotape of the meeting, there are more than four speakers. The content notes [CON] also report that four themes were chosen from the facilitated discussion: access/integrated system of care, no stigma, full and focused funding, and outcomes-focused systems.

In the December meeting, web content was created [TAS] [VID]. The site provided the background of the Commission, Commissioner's names and affiliations, a link to its enabling legislation, and its vision statement. The agenda, business meeting notes, and content notes were made available on the Commission website (Figure 3.6). In addition, the streaming video was broken into smaller units, based on activity, and posted for viewing.

We now have several accounts of the December Commission meeting: four virtual accountings in addition to two textual accountings (minutes and content notes). Each accounting provides a different perspective and interpretation of the Commission's activities. By examining the spoken and written discourses, I am able to track how exchanges were uttered, entextualized, and given agency as tasks and texts. For example, I can examine the facilitated discussion on the Commission objectives, the invited

presentation and testimony, and the public testimony. However, there is no video for the business meeting. The only accounts for the business meeting are its notes and the content notes.

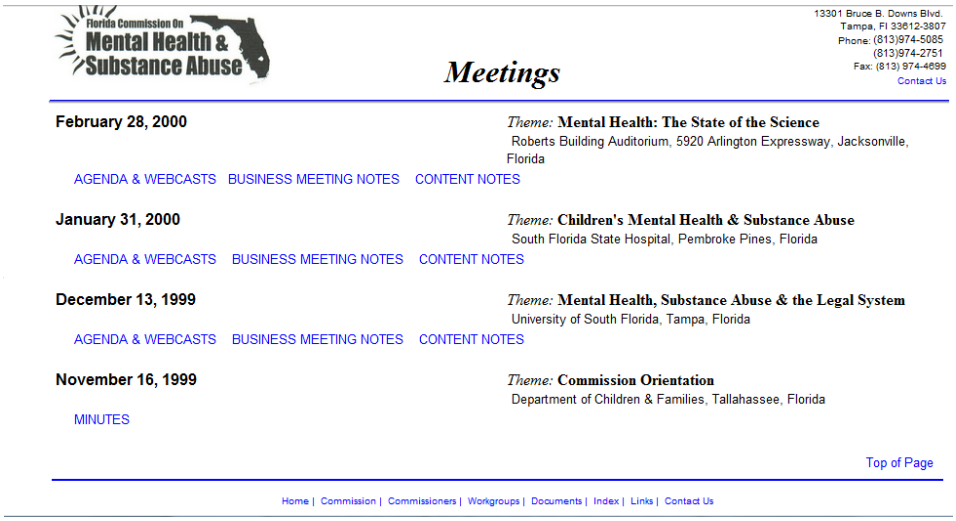


Figure 3.6. Snapshot of Commission Meetings Page

The Commissioners made requests [TAS] for additional documents to visually represent the interaction of the state agencies in the mental health and substance abuse system, to describe funding sources, to provide data for the Commission to use, and to determine names of possible presenters to be sent to the Chair. The Chair identified its first expert, Howard Goldman, who was the senior editor of the U.S. Surgeon General's report on mental health. The report had been officially released earlier that day.

The Commissioners received 26 distinct texts prior to the meeting (not including the December agenda [AGE]), comprising 117 pages total. During the meeting, the Commission heard and received one formal presentation [PRE], seven invited testimonies [EXP], and 63 public testimonies [TES]. From these 71 accountings, they received an additional twenty-six texts, ranging from ephemera [EPH] (16; factsheets, news clippings, and brochures), reports [REP] from mental health and criminal justice

professionals and institutions (3), and photocopies of the expert and invited presentations [PRE] (7). In addition, 5.5 hours of videotape [VID] account for the talk that occurred during this meeting. David McCampbell, a member of the Commission, noted the importance of categorizing testimony in the facilitated discussion [VID]. The business meeting minutes [MIN] reflect his request and subsequent content notes [CON] do categorize the testimony by themes (see Data Excerpt 3.4 and Figure 3.6).

If we also review the texts given to the Commission, we have yet another accounting of the events that occurred at this meeting. The texts given to the Commission members by the Chair and the Executive Director, the experts invited to speak, and the public stakeholders who attended the meeting to speak, show us those elements of the public sector mental health and substance abuse services sector that are key to the social construction(s) of that system by the attendees of the meeting.

The stories told by all the stakeholders, whether providers, consumer, family member, or advocate, emphasize the humanity within the system. Further, these stories did affect how the members of the Commission understood the system. As shown in Excerpt 3.4, the testimony of Terry Taggart, a self-identified consumer and member of the Tampa Bay Depressive and Manic Depressive Association, and John Arnaldi of the Mental Health Counselors Association, had an impact on Commission members Patsy Holmes and Risdon Slate. Both Commissioners asked for additional information, "We need education about what we can do"

The documents they brought, i.e., reports [REP], brochures [EPH], letters [LET], news clippings [EPH], show the many dimensions of the mental health and substance

abuse services system can be seen as aids to the sensemaking process in which the Commissioners were engaging.

Data Excerpt 3.4.

Minutes from the Business Meeting December 13 1999

> Risdon Slate would like to see "stigma busters" in schools to help teach children about mental illness and reduce stigma. He asked if names of possible presenters should be sent to Chairman Shern. The answer was yes. David Shern mentioned that it would be good to get Howard Goldman, the author of the Surgeon General's report on mental health released today, to speak to the commission.
>
> Patsy Holmes noted the prevalence of "funding stories" heard today. At some point, the commission might look at all the different sources of funding. How flexible are they, and how can we change them? If we are going to have a goal of "full funding," we need education about what we can do.
>
> David Shern concluded the meeting by saying we would pull together the themes that had emerged today. There being no further business, he adjourned the meeting at 5:25 pm

At a micro-analysis level, in the December meeting, the visioning session had only one major interchange that involved consumer perceptions (the section of analysis between Mary and Bob provided in pages 1-4 of the Introduction). In the business meeting minutes, Diane Steele, a Commissioner who is a family member of a person with severe mental illness, was commended for her recommendation that the "commission's deliberations focused on listening and cataloging issues" (FCMHSA, 1999, December, p. 1). However, Diane preferred more time on "more time on expert testimony and less on facilitated discussion" (FCMHSA, 1999, December, p. 1). Also, in the business meeting minutes, the importance of categorizing testimony7 was noted by Commissioner David McCampbell (FCMHSA, 1999, December, p. 1). The only stated task in the business meeting notes is the pulling together of themes. Theming ideally would be to identify issues of importance and to the communities that consider them important.

During the public testimony, the video reveals concerns with service access and utilization, medication issues, the need for supported programs, needs of trauma

survivors, and patient care at G. Pierce Wood State Hospital. In the Content Notes, there is a paragraph on what Diane Steele (family member) she sees as essential issues and a summary of issues from the consumers and family members. There are no stated tasks in the content notes.

Preparing for Future Meetings

Figure 3.7 shows the chaining of text and talk from the creation of House Bill 2003 to the December meeting, which established the written and spoken discourses of the Commission, and by doing so, established the processes and the products it would use to account for its work, to substantiate its claims, and to ascribe agency. Note that these same actions occur every month in 2000 until the sunsetting of the Commission.

As the January meeting time came closer, again we see emails [EMA], agenda [AGE], reports [REP], and letters [LET) sent to the Commissioners [COM] by the Executive Director and the Commission Chair. In addition, the Commissioners received 16 distinct texts (not including the January agenda), comprising 98 pages total prior to the meeting. During the meeting, the Commission heard and received one formal presentation [PRE], eight invited testimonies [EXP], and 25 public testimonies [TES].

From these 33 accountings, they received an additional twenty-eight texts, ranging from ephemera [EPH] (16; factsheets, news clippings, and brochures), reports [REP] from mental health providers, professionals, and institutions (5), and photocopies of the expert and invited presentations [PRE], (9). Over 6 hours of videotape [VID] account for a portion of the talk that occurred during this meeting.

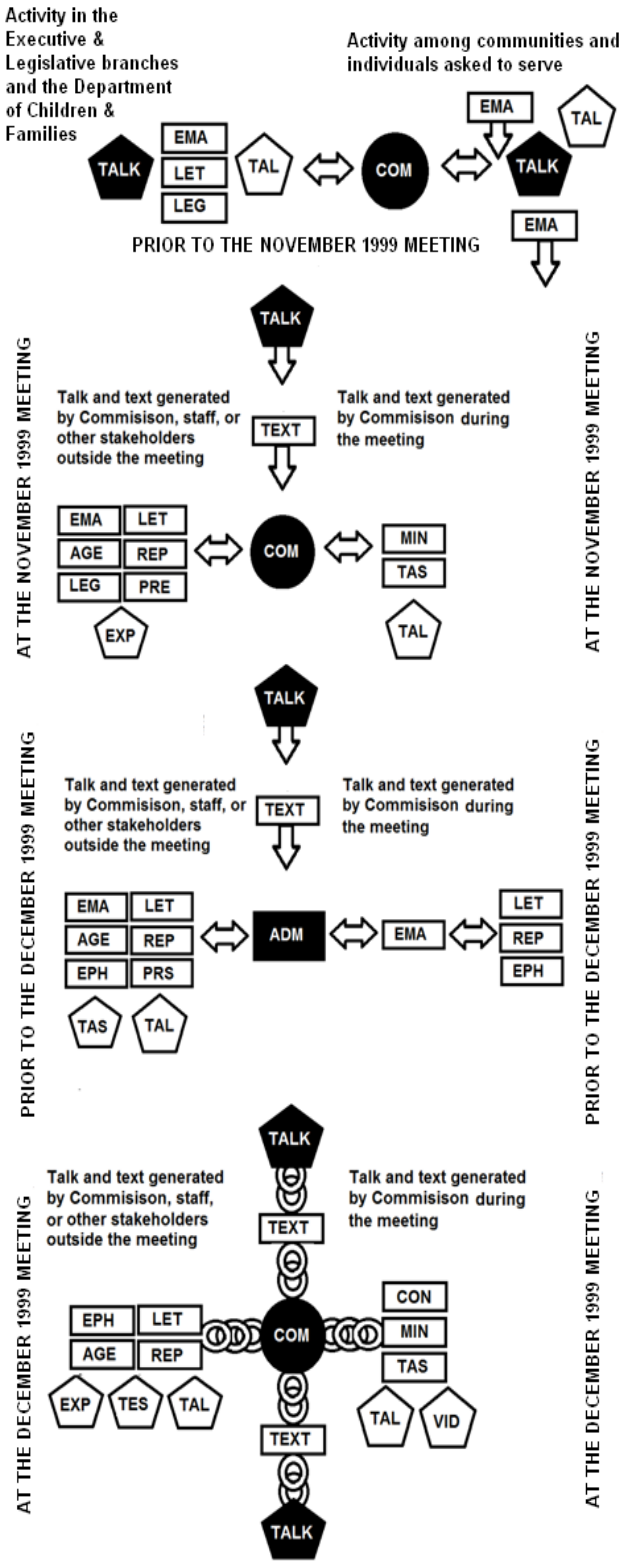


Figure 3.7. Showing the Communicative Chain

Diane Steele continued to press the need for more formal participation for consumers and family members. In Date Excerpt 3.5, the issue, as reported in the business meeting minutes appears to be contentious.

Data Excerpt 3.5.

Minutes of the 31 January 2000 Business Meeting (FCMHSA, 2000 January 31)

> Diane Steele suggested the formation of a second advisory group consisting of consumers and family members to be sure their interests are represented. Daniel Lestage suggested that the two groups be combined, and David Shern expressed concern that this approach might limit consumers' response and participation. Sallie Parks stated that providers are more likely to step forward than clients of mental health/substance abuse services. It was recommended that the motion made to form a second advisory group be tabled until the next meeting to see what response we get from a second letter to non-responders. This will also give us time to more fully develop the Advisory Committee's structure and purpose. The motion was tabled.

In the January Content Notes, of the three invited testimonies given by parents, two parents requested specific services. One parent requested "prevention efforts, such as sex education and contraception, culturally sensitive substance abuse education, round the clock availability of crisis services with home, school and community access, as well as counseling, respite services and advocacy training." The second parent "advocated educating parents, funding facilities on the front end, not when problems worsen, eliminating duplication of services that precludes financial assistance, and more complete psychological evaluations in schools" In the public testimony, it was reported that Gail Bluebird, a consumer advocate and activist urged giving consumers a voice (FCMHSA, 2000 January 31, Content notes). Additional services requested included literacy, occupational therapy, and socialization skills as well as more supported community-based services (FCMHSA, 2000 January 31, Content notes).

By the February meeting, emails [EMA], agenda [AGE], reports [REP], and letters [LET) had been sent to the Commissioners [COM]. In addition, the

Commissioners received 20 distinct texts (not including the January agenda), comprising 143 pages total prior to the meeting. During the meeting, the Commission heard and received one formal presentation [PRE], nine invited testimonies [EXP], and 25 public testimonies [TES]. From these 33 accountings, they received an additional twenty-three texts, ranging from ephemera [EPH] (9; factsheets, news clippings, and brochures), reports [REP] from mental health providers, professionals, and institutions (4), and photocopies of the expert and invited presentations [PRE] (10). Six hours of videotape [VID] account for a portion of the talk that occurred during this meeting.

At the February meeting, again, using a consumer and family member view, the draft of the *Interim Report* is introduced. In the transcript, two members of the Commission, Patsy and Michael, want the draft revised to emphasize that the themes in the *Interim Report* came from the public testimony. Patsy also asks for a close review of the testimony to ensure that the Commissioners are not missing any important issues that need to be addressed.

Data Excerpt 3.6.

Consumer Themes Transcript of Business Meeting

142 Patsy: Um, we might just want to make certain that when we talk about
143 the emerging themes and the major issues that you know most of
144 the public testimony that we heard, I think that there are some very
145 definite themes…
146 David: Uh huh.
147 Patsy: And we just want to make sure that those major themes that we are
148 hearing in public testimony to date are included in all this, and more
149 more than likely it is, but we just might want to keep
150 [indistinguishable].because really this was like in an ideal world

Patsy is adamant that the *Report* explicitly states the themes were taken from public testimony, that is, from consumers and family members ("State of the Science" transcript,

Appendix B). Note the use of "we" with "want." Patsy's use of "we" signifies her belief that she has the consensus of the members of the Commission. Further, this is not simply a casual request, but more of a directive. Presentation of self and impression management (Goffman, 1959) are critical in the preparation and receipt of this report. The importance of the consumer and family voices in determining themes cannot be dismissed. This importance is reflected in the February business meeting minutes and content notes (Draft Excerpt 3.7).

Data Excerpt 3.7.

Consumer Themes February Business Meeting Minutes

> Patsy Holmes asked that past content notes be checked to be sure all themes were covered. Michael Spellman asked that it be made clear that public testimony had been integrated into the Commission's deliberations" (FCMHSA, 2000, February 27).

The February minutes note a request by Commissioner Patsy Holmes that that the Commission staff examine the past content notes to ensure all themes were covered. This follows a previous statement in the December business meeting minutes by Commissioner David McCampbell on the importance of categorizing testimony. Including all the invited and public testimony identified for the *Interim Report* by the Commission, the themes are broadly stated as universal assessment, improved access, integrated, caring, high quality care; appropriate tracking technology, reduced stigma, full-focused funding, and outcomes tracking and feedback (I explore this more fully in Chapter 5).

We see the same steps and similar parallels repeated again as the remaining meetings are prepared. There are numerous emails between the Executive Director and

the Commission members regarding the upcoming agenda, attendance, and venue. Speaker invitations are sent, adjustments are made to the docket. Publicity is generated with mailings to consumer groups, postings to listservs, information posted to the website, notifications sent to agency staff, and newspaper ads are placed. Media is alerted with news releases on the Commission; the Chair writes op-eds for the general media. In addition, the Commission is featured in FMHI's quarterly newsletter *Policy Brief,* as well as many other department newsletters generated as part of a larger dissemination strategy through FMHI's partnerships with community agencies, consumer and family member groups, and advocacy organizations. Emails are sent and received by the Chair and the Executive Director, Commission members, and administrative staff. These emails are answered or forwarded. In some cases, the email is addressed at the next Commission meeting.

Meetings are recorded and documented. Actions are noted. Accountings are performed. Talk is entextualized in the content notes and the business meeting notes, and on the website. Florida's Public Records Law (F.S., Chapter 119) states that any records made or received by any public agency in the course of its official business are available for inspection. The Government in the Sunshine Law (F. S, Chapter 286, 1967) establishes a basic right of access to most meetings of boards, commissions and other governing bodies of state and local governmental agencies or authorities. For any public policy commission or task force established by the Governor or Legislature, the business meeting minutes are not used exclusively by a commission or task force, but are considered a matter of public record. Hence, these accountings help to establish the Commission's performance of its duties to numerous stakeholder groups. In the case of

the February meeting, the communicative chain of text and the talk document the creation of the interim report, the first formal accounting required by HB 2003. I discuss the creation of the interim report more fully in Chapter 5.

Parsing Written and Spoken Discourse

In addition to chaining the written and spoken discourses of the Commission, we can learn more about the reach of the Commission as well as which communication genres are preferred for which communication communities. To who a document is intended illustrates the "reach" of the writer (Kaufer & Carley, 1993, pp. 126-127). Are documents intended for staff only? For the public? For politicians? From a geographical perspective, the management of the Commission was in the central part of the state in Tampa. The Commission, however, was subject to the Governor of the state, housed in Tallahassee four hours away by car. The Commission members and the Commission stakeholders were throughout the 58,560 square miles that comprise the 67 counties in Florida.

After processing and classifying the Commission documents, I classified the documents using Gunnarsson's (1997, p. 146) matrix of communicative communities: Local-Private, Local-Public, Distant-Private, and Distant-Public. Figure 3.8 shows the preferred choice of genre (shown in all capital letters) among these communities.

	Local	Distant
Private	SPEECH writing	SPEECH writing
Public	SPEECH WRITING	speech WRITING

Figure 3.8. Gunnarsson's Communication Communities

The first group of communicative communities, Local-Private, applies to the interactions of the Commission members among themselves and to the interactions

among the support staff. In this group are memos, personal notes, and telephone conversations. The second group, Local-Public, applies to the interactions of the Commission members and the support staff that generates the documents for study by the Commission. In this group are the formal business and content notes taken by Commission staff. Since the business of the Commission falls under Florida's Sunshine Law, both business and content notes were publicly available on the Commission's website. The third group, Distant-Public, is the institutionalized talk that informs the Commission as to best practices, epidemiology of mental illnesses, and population impacts. In this group are the presentations and documents given by the invited experts as well as the Surgeon General's report on mental health. Many of these documents were posted on the Commission website. The last group, Distant-Private, addresses the constructed discourses among stakeholders who may be affected by policy and program implementation. This group contains the invited testimony from legislative, state, and agency staff; members of the mental health provider community, corrections (part of the de facto mental health system), academia, family members, and consumers.

Surprisingly, although the Commission members were involved actively in discussions and interactions with external speakers and stakeholders, the Commission Chair, the Executive Director, and FMHI faculty generated more complex (upper level) documents, such as the interim, final, and workgroup reports. These reports, in response to a legislative mandate, have political ramifications. Their audience includes the Governor of the state of Florida, the President of the Florida Senate, and the Speaker of the Florida House of Representatives. Hence, these texts will not mirror routine reports or pre-formatted texts. Authors will need to make a series of decisions regarding content,

document structure, and choice of wording. However, the documents also will be reviewed and approved by the Commission.

Consider also that not all of the texts generated or received by the Commission can be integrated into the reports. Certain talk will be preferred and included, while others will be dispreferred and discarded (This is discussed in more detail in Chapter 5). Gunnarsson (1997) suggests high-level documents such as these are scrutinized more closely by distant-public communities, of which the Governor and the legislative representatives, as well as the distant-private, which envelops the future discussions of the legislature in its review of the Commission recommendations.

The Executive Director also wrote more mid-level documents, such as letters, memoranda, and notices of meetings. The FMHI faculty and the Executive Director prepared descriptive and summarizing (mid-level) documents. Staff members were in charge of minutes and lists, which Gunnarsson considers low-level texts. However, the Executive Director also handled much correspondence from persons who shared their experiences or the experiences of their family members. An example of this is shown in Data Excerpt 3.8.

In the first interaction between Gail and Nancy we see several things. First, the discourse community to which a person self-identifies is established. Gail is a family member. Nancy is part of the Commission. Gail is writing as a mother. Nancy is writing as a person in authority, as an Executive Director. Gail's correspondence is middle-level, in that the letter is a summary and a request for assistance.

Nancy's response, however, is low-level; she simply acknowledges receipt of the letter and that she will forward the letter to the Commission for review. In Gail's second

letter, also middle-level, she again requests action, with more details and naming individuals.

Data Excerpt 3.8.

Interaction between Gail Mitchell and Nancy Bell

Date	From	To	Content	Level	Type
[no date]	Gail H. Mitchell, Family member	Nancy Bell, Executive Director FCMHSA	Explains abuses her daughter suffered in the south Florida mental health system. Asks for the Commission to stop the abuse.	Mid	Distant-Private/ Public
8/8/00	Nancy Bell Executive Director FCMHSA	Gail H. Mitchell family member	Thanks Gail for letter about daughter's experiences; states most everything wrong with the current mental health and substance abuse system is in her letter; will forward letter to Commissioners and post on website	Low	Distant-Public
8/18/00	Gail H. Mitchell Family member	Nancy Bell, Executive Director FCMHSA	Asks for follow-up to abuses her daughter suffered at specific MH institutions by specific personnel	Mid	Distant-Public
8/24/00	Nancy Bell Executive Director FCMHSA	Gail H. Mitchell family member	explains purpose of Commission, regrets not able to investigate specific situations, but hopes recommendations and subsequent new legislation will improve the system and correct problems such as those experienced by Gail's family	Low	Distant-Public

Nancy's response, again, is low-level. Traditionally, communities based on contact at a distance engage in written communication, classifying these interactions as distant-public. However, I suggest that Gail's letter is simultaneously distant private and public.

It is distant private in that she is sharing personal information with Nancy with a request for assistance; however, her letter is to a public body. Further, under Florida's Sunshine Law, Gail's letter is now part of the public record of the Commission's business. Since the correspondence is now part of the public record, another agency could choose to investigate further.

What actions were taken with Gail's letters? Nancy duly reported she had received emails and letters from consumers and family members to the Commission. She forwarded those emails to members for their review, and offered to provide photocopies of paper letters to members for their review. Gail's letters and requests were not among the narratives selected for inclusion in the *Final Report.*

Summary and Conclusion

Gunnarsson (1997, pp. 162-163) suggests that in the "analysis of the role of spoken discourse in communicative processes, the relationship between activity and medium is relevant." Consider the dependence on texts to generate discussion that begins within the first few minutes of the Commission meetings as David Shern, the chair of the Commission, reminds the Commission of the business meeting notes and the content notes of the public testimony that documents the talk from previous meetings. The first order of official business is to review the minutes of the previous meeting and address any questions or additions to the minutes. Public meetings, such as the Commission, must have written agendas and written minutes. Traditionally, this would be the only accounting for their work. However, with the new internet technologies available in the 1990s, the Commission also made videotapes of its meetings publicly available. We can see the intermingling of talk and text. The talk-in-interaction is entextualized into

minutes and content notes, and further recontextualized in subsequent meetings and the deliverables of the Commission: the interim and final reports. Conversely, we can also argue that a written report, such as *Mental health: A report of the Surgeon General*, was the starting point for the conversations which led to the establishment of the Commission and its charge.

Public policy workgroups and their stakeholders generate an enormous amount of written and spoken discourse before, during, and after a public policy problem has been identified. To understand effectively the processes involved in policymaking, Gunnarsson (1997) suggests an analysis of the size and duration of the group, the transactional content of the products, and the relationships between written and spoken language. Such an analysis should examine how the different types of information are conveyed within the group, how different individuals communicate with each other, how each attempts to attain its goals, and the relative openness of the group. Hence, patterns and use of writing and speech may show the shared knowledge, evaluations, attitudes, and norms of a policy group, from its inception to its final recommendations.

Sensemaking in public policy does not occur in a vacuum. It is found in the reason an organization exists, of the roles with which individuals identify, the activities they see as valuable, and their investment in a given course of action. If an item is able to act for us when we are not physically or consciously present, it exhibits durability and transportability (Innis, 1951). It is this durability and transportability that may be noticed in the talk and text creating and generated by the Commission's, from its position as a filed bill to its enactment as legislation to its inception as a political entity to its role as author of its final report.

When examining the chains of communicative events, spoken and written activities are intermingled; however, in certain cases a written text is often a complement or a response to an interaction that is spoken. Meetings are arranged through talk and documented through text, i.e., notices, emails, websites, and memos. Meetings are given voice by the speakers and participants while they are entextualized through visual presentations, minutes, and content notes. Meetings are followed by feedback, comments, debriefing, and evaluation in talk. This is institutionalized in formal business minutes, draft reports, website updates and postings, and formal videos of the event.

In Chapter 4, I examine how expert and evidence was invoked by the Commission in its sensemaking of the mental health and substance abuse services system.

CHAPTER FOUR: DEFINING "EXPERT" VOICES

> Policy analysis is an applied social science discipline which uses multiple methods of inquiry and argument to produce and transform policy-relevant information that may be utilized in political settings to resolve policy problems (Dunn, 1981, p. 35)

As I stated in Chapter 1, public policymaking begins when people recognize there is a problem. The problem can be concern for a government's mission, objectives, or purpose. Other problems may be the illumination of wider societal costs, such as the latent or unintended consequences of government interventions, or consideration of alternatives for unrepresented or disenfranchised groups that participate in public programs. Policymakers make use of policy analyses to aid in framing and resolving complex issues. How the "multiple methods of inquiry and argument" of Dunn's definition are utilized in making cogent arguments depend upon a number of factors. I suggest the most important factors may be who constructs the problem and which analytical lens is used.

The language of policymaking and its analyses are simultaneously constructive and constitutive. Policymaking deals with constructs; after all, "we start from words, we work with words, we report with words" (Archibald 1980, p. 179). The words that are chosen to describe, explain, or recommend come from numerous communication communities and discourses. Each community, each discourse, believes that its voice has the potential to transform social and political institutions. These voices, contained in a

policy analysis, are asking, "What happens when we intervene in a social system in this way rather than that way?" My question is the following: Which voice is selected as the expert voice and why?

To address how expertise is identified and his or her role in the policy making process, I now move to examine the construction of "expert." I suggest a number of factors play a role in the construction of "expert," ranging from skepticism to solidarity. These factors address the architecture of participation, an individual's sense of efficacy within the system, issues of membership, inclusion, and boundaries, and the locus, nature, and specific exercise of power in the organization. I see discourse analysis as a tool for disentangling public dialogue about complex and value-laden policy issues through the structure and function of language. Using this method, I now account take account of the multiple ways in which participants make their claims around problem identification, the subtle differences found in the expression of their views, and insight into the ideology or belief system of stakeholders and actors (Schön & Rein, 1994).

In this chapter, I use a discursive approach to examine how one is perceived as expert, through the twinned areas of evidence and credentialing. I examine how the voice of the expert is constructed, i.e., who is an expert and the value of the role of "expert." I use data from the "Mental Health: The State of the Science," the third public meeting of the Florida Commission on Mental Health and Substance Abuse held in Jacksonville, Florida on February 28, 2000. This meeting generated the following data: invited presentations, invited testimony, public testimony, meeting minutes and content notes prepared by Institute note-takers, and handouts given by participants to the Commission for later review. Included in the handouts was the federal report, *Mental Health: A report*

of the Surgeon General (U.S. Department of Health & Human Services, USDHHS, 1999). *Mental* Health was the first ever report published by the U.S. Surgeon General's Office. The invited presentation was by an acknowledged expert in mental health research and policy, Dr. Howard Goldman, senior scientific editor of the then-recently released Surgeon General's report on mental health. The invited testimony revolved on "Issues in Practice" as did the public testimony from mental health professionals, persons with mental illnesses, and others, such as Ruth O'Keefe, a family member of a person with mental illness and an advocate. In the next section, I show how evidence informs health services policymaking, and the levels of "expert" that comprised the Commission's understanding of the public mental health sector.

Mental Health Policymaking and the Role of Research

The *de facto* mental health system (Regier et al., 1993) in the United States is characterized as having distinct sectors, settings, financing, oversight for care, and multiple trajectories into the system. It is comprised of both public sector services (directly operated by government agencies and services financed with government resources) and private sector services (directly operated by private agencies or financed with private resources). It provides acute and long-term care in home, community, and institutional settings, across the specialty mental health sector, the general medical/primary care sector, and the voluntary care sector. A variety of funding streams distributed by federal and state agencies affect financing of care. Professional licensing and accreditation organizations, managed care provider entities, advocacy and regulatory agencies, and healthcare policymaking groups influence the delivery of care. In addition, state laws, administrative policies, funding priorities, advocates' concerns, and

organizational culture and climate create additional structures that are involved in change efforts. How one enters the system greatly influences how, when, and what care one receives.

However, the public mental health is not just a "delivery system" scientifically constructed by "experts." In addition to being a complex system of sectors, settings, streams, and trajectories, there are many social and professional languages in the public sphere. Each stakeholder has a particular perspective on how to formulate and name the issues under study or the population affected by a policy change. Further, in this system, persons with mental illnesses may be known by their illness (e.g., the "schizophrenic"), their roles (e.g., client, consumer, or patient), their trajectory into care (e.g., corrections, hospital, involuntary commitment), the current paradigm (e.g., caretaking, empowerment, or recovery), or by larger system issues (e.g., economics and financing of care).

Public sector mental healthcare in Florida is a perennial "hot topic", with the continual publicity surrounding management of services, involuntary commitment, prevention practices, client-centered care, the recovery paradigm, and barriers to appropriate and timely treatment, especially in light of the different funding and services trajectories for persons with both mental and substance abuse disorders. Hot topic areas often become critical issues, calling upon diverse members of a community to address the issue at a policy level.

In the policymaking process, participants negotiate roles (identity), create social order (relationships to one another and the community), develop knowledge (what each views as true), and elicit values (setting social policy). Individuals situate themselves, not only through conflict, but also through intersubjectivity, i.e., the process of

establishing one's identity and sense of self and the claims made through discourse. Individuals speak for self, for another, or for a larger "other" such as an agency, a legislature, a division, or a policymaker. To do so, various discursive strategies make claims to the "extended we." Further, participants may or may not choose or create these discourses. Even the meanings that are rejected "continue to inform our responses, if only because we react against them" (Sederberg, 1984, p. 5). As individuals and institutions construct public policy, they use institutional and social language "shorthand." Such shorthand influences stakeholders across political, economic, and societal dimensions (Mehan, 1996).

Interpretative understandings are not arbitrary. The giving of reasons and the assessment of arguments in the claims, claims-makers, and the claims-making process (Best, 1989) create these understandings. Since the public mental health system is a multifaceted construction of discourses – ideologies, philosophies, science, beliefs, claims, and policy initiatives – the next step is to examine the speaker's view of reality at a point in time and to attend to and apprehend each speaker's political language. Our understanding of policy and policy outcomes is inseparable from the ideas, theories, and criteria used to analyze and describe policy (Majone, 1989). After all, a defining characteristic of policy problems is "precisely that controversy over their meanings is not resolved" (Edelman, 1988, p. 3).

To resolve definitions and meanings of a "policy problem," policy makers privilege rational or expert knowledge creation and policy experts. Traditional knowledge is "legitimate," with little discussion of lay or non-expert experience. Expert knowledge, such as the close relationship of governments with established think tanks,

for example, is acceptable, not problematic. "Facts" are "theory-laden" (Unger, 1975); hence, facts are open to interpretation, that is, policy actions must be seen as resting on interpretations reflecting and sustaining specific ideologies and beliefs. Ambiguous claims also serve an important political function by ignoring meanings, by redefining meanings to better suit the prevailing discourses, or by defining a problem as a "non-problem." Policy-makers determine the meaning of empirical data and expert knowledge by how each fits within the particular arguments of a co-constructed ideological framework.

As Weick (1995, p. 20) reminds us, "Once I know who I am then I know what is out there," institutional talk is not neutral. When an individual identifies with an institution, he or she incorporates its talk into his or her own way of knowing. This talk is no longer neutral. It is its own political actor with a policy agenda, supported by selected experts and evidence. Participants may not recognize ideological constructs embedded in an existing discourse; they simply accept it as the "status quo" (i.e., how the world works). Within this status quo are the experts and the evidence needed to provide predictability for policymakers and legitimize their choices as acceptable to the majority.

There is nothing new about the idea that policy and practice should be informed by the best available evidence and experts. From the 1950s to the 1970s, research was a key element in policy analysis. Using scientific research, the "world as we know" it could be recontextualized, new decision maps could be validated, and conventional assumptions challenged (Weiss, 1977). Policymakers, however, did not view research as policy. It was seen as a process of argument or debate to identify a public concern and to set an agenda. During the 1980s and 1990s, a more dialogic model emerged among

researchers and policymakers as knowledge was considered to be inherently contestable (Giddens, 1987). It was also during this time that significant advances in the sciences and neuroscience provided new evidence in the diagnoses and treatments for somatic and mental illnesses.

By the mid-1990s, the emergence of evidence-based medicine created an impetus to move towards evidence-based health policymaking. There was an assumption that there is a linear relationship between research and policy. This model is consistent with the traditional scientific model of policy analysis, in which research evidence can and should influence public health policy. Public health policies are those that protect health and prevent illness in entire communities or populations. The notion that research can help identify policies and programs that work to improve public health was central to many federal reports published during the 1990s. The research evidence, from the National Institutes of Health (NIH), the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration (SAMHSA), was sufficiently strong to be translated into public health policy recommendations.

However, research evidence may be dismissed as irrelevant if it comes from a different sector or specialty. In addition, a lack of consensus about the research evidence because of its complexity, scientific controversy, or different interpretations may impede if not stall the policymaking process. Policymakers may value other types of evidence, such as the life-world or "lived" experience of a person with mental illness, opinions of colleagues in the health field, and medico-legal reports by professional, federal, or advocacy agencies.

Constructing the Voice of the Expert

Linnell (1998) suggests that, within any professional community, there are three types of discourse: interpersonal, interprofessional, and professional-lay discourse. Interpersonal discourse is discourse within specific professions, such as academia, politics, or health. He defines interprofessional discourse as the discourse between individuals or representatives from different professions who engage at workplaces, in professional meetings and conferences, in public debate arenas, and through media. Finally, Linnell defines professional-lay discourse as those interactions between professionals and laypersons; from these meetings the professionals then speak or write for the laypersons. Examples of this "speaking for" are found in psychotherapy sessions or legal consultations (Bartesaghi, 2009; Mehan, 1996) as well as in public policymaking. I suggest the Florida Commission on Mental Health and Substance Abuse is an example of professional-lay discourse in public policymaking.

The Commission conducted a systematic review of the overall management of the state's mental health and substance abuse systems. To facilitate opportunity for public education and testimony, the Commission met monthly in different locales around the state. Each meeting had a theme and provided opportunity for open public testimony. Early meetings included facilitated group discussion and invited expert speakers. In addition, the Commission actively collected evidence from a number of sources, soliciting presentations from national and local experts, family members, advocates, and persons with mental illnesses and substance abuse disorders.

The Commission also requested a review of the research literature on best practices, information on the structure and practice of the many agencies and

organizations providing services to persons with mental illnesses and substance abuse disorders. The Commission had to make sense of all of those texts it had charged with the role of expert: the life-world experiences of the Commission and its many participants, legislative and agency texts, organizational practices and structures as concretized in text, and the interactions between the participants and the artefacts created by and for the Commission. The final report, created by the Commission, was the culmination of a year of open deliberation and proposed changes to the existing public mental health service systems. I examine two instances of the construction of expert voices in testimony. The first deals with the voices embodied within text as evidence; the second deals with the identification of an individual as expert.

Determining Evidence and Expert in the Nation's Health

Health services research does many things. It not only informs policymakers about pressing issues it provides data and resources. It guides the implementation process; and it evaluates programs or policies to determine whether programmatic or policy goals are met. Health services research in public sector health and mental health is modeled on the public health model. This model is characterized by 1) its concern for the health of a population in its entirety and 2) by an awareness of the linkage between health and the physical and psychosocial environment. Although the more traditional areas of diagnosis, treatment, and etiology are part of health services research, public health focuses on the epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services (Last & Wallace, 1992).

In the United States, the Office of the U.S. Surgeon General is charged with the "protection and advancement of the health of the Nation through educating the public" and to "articulate scientifically based health policy analysis and advice to the President and the Secretary of Health and Human Services (HHS) on the full range of critical public health, medical, and health system issues facing the Nation" (Office of the Surgeon General, n. d., para. 1-2). The Surgeon General reports to the Assistant Secretary for Health, who is the principal advisor to the Secretary of the Department of Health and Human Services on public health and scientific issues.

Prior to 1999, the Surgeon General had reported on a number of national public health concerns, such as the relationship between tobacco and health, the needs for additional services and supports for children with special health care needs, acquired immunodeficiency syndrome (AIDS) and the public's health, the relationship between nutrition and health, and the relationship between physical activity and health. Many of these reports examined in close detail the current knowledge base and research findings. The Surgeon General brings forward issues from pertinent scientific disciplines, reviews and evaluates the evidence, and draws definitive conclusions on the relationship between that issue and health in general. As the Surgeon General is responsible for the "protection and advancement of the health of the Nation", his or her reports therefore play a major role in raising awareness of important health issues and generating major public health initiatives.

When President George Bush signed House Joint Resolution 174 which designated the decade of the 1990s as the "Decade of the Brain" (President George Bush, 1990), he reminded the nation that "millions of Americans are

affected each year by disorders of the brain" (para. 2); however, these same Americans and their families have cause to be hopeful, in large part due to the innovative research the country was conducting. A large interagency initiative between the National Institute of Mental Health and the Library of Congress began; its purpose was to introduce Members of Congress, their staffs, and the general public to cutting-edge research on the brain and its applications to improving the lives of persons with mental illnesses. Seven years into the Decade of the Brain, then U.S. Surgeon General David Satcher authorized the preparation of *Mental Health: a Report of the Surgeon General* (*Report*).

Under the guidance of the Surgeon General, the Substance Abuse and Mental Health Services Administration (SAMHSA) worked in partnership with the National Institute of Mental Health (NIMH) of the National Institutes of Health to develop this report. The three agencies created a Planning Board, comprised of individuals representing a diverse range of stakeholders. The Board included academicians, mental health professionals, services, and neuroscience researchers. In addition, there were federal divisions, offices, centers, and institutes and private nonprofit foundations with interests in mental health on the Board. Self-identified consumers of mental health services and their family members were also selected to be Board members (US DHHS, 1999, pp. 23-24).

Two years in the making, the 487-page report pulled together the evidence base of the current knowledge in the prevalence, diagnosis, treatment, and outcomes of mental illnesses and substance abuse disorders. In the preface, Donna Shalala, then Secretary of the U. S. Department of Health and Human Services (USDHHS) calls it a "seminal

report" that will allow us to "take what we know and to advance the state of mental health in the Nation" (USDHHS, 1990, [iii]). In Excerpt, 4.1, we see the reframing of the mental illness, using the science of the past fifty years to bring mental illness out of the darkness of despair into the light of successful treatment and recovery. In this statement, we see the two close relationships afforded by this Office in the performance of its duty.

Data Excerpt 4.1.

From the Preface of the 1999 Surgeon General's Report

> This first Surgeon General's Report on Mental Health is issued at the culmination of a half-century that has witnessed remarkable advances in the understanding of mental disorders and the brain and in overall appreciation of the centrality of mental health to overall health and well-being (USDHHS, 1999, p. 3).

The first relationship, between science and health, helps to (re)construct how mental illness is perceived, not as an amorphous "mental" thing but as a biologically-based disorder, like cancer or diabetes. The second relationship, to health and well-being, accomplishes two things: it grounds mental health as a public health issue and gives mental health the same emphasis as somatic (physical) health. By 1999, the Decade of the Brain was coming to a close, providing ample opportunity to showcase the state-of-the-science. As I show later in this chapter, the *Report* takes full advantage of science to further its agenda.

The *Report* is ambitious in its coverage; not only are mental illnesses and substance abuse disorders medically complex, its service systems are organizationally complex labyrinthine structures. The first two chapters of the *Report* introduce the themes and build the science base of the report. Chapters 3, 4, and 5 are population-based, examining children, adults, and older adults with mental illnesses and substance abuse disorders. Chapters 6 and 7 address larger system issues: the organizing and

financing of mental health services as well as the federal privacy laws that protect patient confidentiality and privacy. The final chapter of the *Report* is optimistic: A Vision for the Future.

The National Library of Medicine (n.d.) suggests that the "real outcome of Surgeon General publications is to *give evidence* to support health promotion/disease prevention policies at all levels - national, state, local, family, individual, professional and non-professional" (para. 6, italics added). However, the idea that evidence should play major part in informing public health policy is a continual point of discussion among policymakers, policy analysts, and researchers (Booth, 1988; Hanney et al. 2003; Innvaer et al., 2002; Lavis et al., 2002; Rosenheck 2001; Weiss, 1979).

Evidence, within a policy perspective, takes many forms: a problem exists, examples of the impacts of policies on people and organizations, controlled evaluations of policy initiatives, feedback from natural experiments with variation, and historical evidence (Whitehead et al., 2004). Greenlaugh et al. (2004) suggest that findings that are unambiguous and easy to apply are more likely to be acted upon, especially by organizations with similar institutional discourses or by individuals who share common attributes with those described in the research. However, the extent to which policymaking is informed by evidence may arise from a number of different perspectives.

There are a number of questions raised in systematic reviews of the research, especially when the research must be distilled and synthesized. Questions range from issues of authority to questions of empiricism. For example, is evidence only that research that is citable? Another question may deal with a preference for a specific discipline, as in "Is any professional (expert) inquiry that assists in problem solving

considered evidence?" Yet another question may prefer tangible, measurable knowledge to experiential knowledge: "Is evidence only that which is explicit, as in the randomized controlled study, or is tacit knowledge evidence?" With these questions in mind, I ask my questions. Does the *Report* give evidence? Does the *Report* establish itself as an expert voice? If so, how? Let us start with the idea of evidence.

Text as the Voice of Evidence: *A Report of the Surgeon General*

What is evidence? Evidence is often defined as proof supporting a claim or belief. In public health, evidence typically refers to the effectiveness of an intervention in achieving an outcome that creates lasting change(s) in the health of an identified population. This evidence is usually published in scientific literature such as in professional journals, books, or government reports to assist in moving research to practice. Evidence is determined by a number of factors. These include quality of the evidence determined from the rigor of the study design, study replicability, generalizability of study, statistical significance, bias, attrition, intervention focus, and sustainability of impact (Hanson & Levin, 2012).

In Chapter 1, the *Report* states that it uses the scientific method of establishing evidence through experimental (causal) and correlation research. It also acknowledges gaps in the mental health knowledge base, especially in mental health promotion and illness prevention (p. 454), and in moving research into practice (USDHHS, 1999, pp. 455-456). However, there are rules as to what will be accepted as evidence and by what community.

Levels of Evidence

In Chapter 1, the Surgeon General frequently reassures the reader that the *Report* that the bulk of the cited studies are empirical, not theoretical, research. This is important in that the *Report* wants to hammer home its message: mental illnesses can be successfully treated. To do this, it must show a compelling body of evidence. However, in science, "no single study by itself, however well designed, is generally considered sufficient to establish causation" (USDHHS, 1999, p. 10). To be accepted across the scientific community, other investigators must be able to replicate the findings with an appropriate level of evidence. The *Report*, therefore, establishes its levels of evidence.

The "level of evidence" is defined as the strength of the evidence amassed for any scientific fact or conclusion (USDHHS, 1999, p. 10). There are four levels of evidence widely accepted in the scientific and health communities: 1) randomized clinical trials, 2) non-randomized clinical trials, 3) observational studies with controls (e.g., retrospective, interrupted time series studies, case- and cohort-control studies) and 4) observational studies without controls (e.g., cohort and case studies without controls). Although the gold standard is the randomized clinical trial, there are different levels of evidence. In science, even though not all forms of evidence are of equal value, all levels of evidence are important and have their respective values.

The *Report* clearly establishes two levels of evidence. The first level of evidence is the use of evaluative guidelines established by external experts, such as determining prevalence through epidemiological studies and the use of selected diagnostic tools. The second level of evidence is the use of a formal, statistical technique called meta-analysis (USDHHS, 1999, p. 11). The *Report* uses the first level of evidence to determine clinical

effectiveness and outcomes of psychotherapeutic interventions; the second level of evidence is used in the meta-analytic and systematic review of over 3,000 academic research studies on mental illnesses and substance abuse disorders.

Before clinical effectiveness can be determined, the first step is to determine the extent of the affected population. Drawing heavily on the neuroscience of mental health and integrative brain science, the *Report* addresses the epidemiology of disorders (i.e., distribution and determinants of mental disorders in population groups), and prevention and treatment. The *Report* consistently references three large epidemiological studies: the Global Burden of Disease study (GBD), the Epidemiologic Catchment Area Study (ECA), and the National Comorbidity Study (NCS).

The GBD is an international study, conducted by Harvard University on behalf of the World Health Organization (Murray & Lopez, 1996). The GBD established the severity and burden of mental illness on health and productivity worldwide (Murray & Lopez, 1996, p. 4). Of the almost 500 sequelae of diseases and injuries examined for incidence, prevalence, duration, and mortality, Murray and Lopez determined that mental illnesses and alcohol use disorders placed among the *top ten* causes of disability (my italics). The ECA (Regier et al., 1993) and the NCS (Kessler et al., 1994) are U. S. studies that established national prevalence rates for mental disorders (2.8%) and comorbid disorders (3.3%) respectively. Two or more mental illnesses and/or substance abuse disorders occurring at the same time in an individual are called comorbid disorders. Consider that 19,057,542 persons live in Florida (U.S. Census Bureau, 2012). Approximately 5,336,117 persons may have a diagnosis of a mental illness (2.8% x *n*), or almost one in four. Like somatic diseases, such as cancer, prevalence is affected by two

factors: the incidence of a disease and how long a person normally lives with the disease. Also, like cancer, mental illnesses and substance abuse disorders are considered chronic diseases, in that treatment may be required over a person's lifetime. Knowing the prevalence of a disorder or cluster of disorders is essential in providing services to persons who may be affected as they are affected rather than creating services systems after a diagnosis is made.

The three studies (GBD, ECA, and NCS) are used as the authoritative standards in discussions on the prevalence of and debilitating nature of mental illnesses and substance abuse disorders. Most of the evidentiary "weight" the reports carry come from the rigor of the study designs and the validity of the statistical analyses. However, some of the weight comes from their parent organizations. The sponsoring organizations of these three studies, the World Health Organization, the National Institute of Mental Health, and Harvard University are recognized as expert by academic, scientific, and lay communities.

However, to determine the prevalence of a disorder, there must be a way to name it. Mehan (1983, p. 188) reminds us that a number of "discursive and organizational arrangements provide for this manner of making decisions." For the Surgeon General's *Report*, the authoritative standard for the naming of a disorder is the *Diagnostic and statistical manual of mental disorders* (*DSM*). Used by researchers, clinicians, and practitioners as a resource for the classification of mental disorders, the *DSM* defines mental illnesses and provides the theoretical assumptions upon which the definitions are based. Seen as a common nomenclature based on a consensus of the contemporary knowledge about mental illnesses and substance abuse disorders, the *DSM* had recently

undergone a significant revision during the 1ast eight years. Consider that the revision process also established the authority of the *DSM-IV* (American Psychiatric Association, 1994) as the diagnostic resource for the *Report*.

The 1994 revision of the *DSM III* involved a steering committee of twenty-seven experts, thirteen work groups of 5-16 expert members each, and over 200 expert advisors (Frances, Widiger, & Pincus, 1989, p. 374). Since the most important goal in the preparation of DSM-IV was to increase the empirical documentation upon which the diagnostic system is based (Frances at al., 1989, p. 374), the *DSM-IV* revision groups provided a detailed and documented three-stage process of empirical review. The three stages included comprehensive and systematic reviews of the published literature, re-analyses of existing data sets, and field trials funded by NIMH, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism (Frances et al., p. 374). Foreshadowing the Surgeon General's quote that "no single study" by itself is sufficient to establish causation, 150 systematic literature reviews were generated by the Work group members. The field trials assessed the acceptability, feasability, coverage, generalizabity, reliability, and construct validity of criteria sets and their diagnostic algorithms (Burke, 1988). To ensure the documentation of its scientific base, the *DSM Sourcebook* (American Psychiatric Association, 1994) documents the systematic process of the empirical review process and provides the rationale and empirical support for DSM-IV decisions.

The second level of evidence is meta-analysis. Meta-analyses and systematic reviews are very common in health care. They are used as current awareness tools to help researchers and practitioners keep up to date in their field, to develop clinical

practice guidelines, to appraise new technologies and interventions, and to select justify new areas of research. Meta-analysis specifically refers to the use of statistical techniques in a systematic review to integrate the results of included studies. A systematic review is a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research (Higgins & Green, 2011). It collects and analyzes data from the studies that are included in the review, and minimizes bias by using explicit, systematic methods (Higgins & Green, 2011). The importance of meta-analyses and systematic reviews is in the framing of the research question, and the choice of the lens used to study the research. This is critical in health services research where the choice of a statistical analytic method may provide a dramatically different perspective than a clinical analytic method if the latter would be more appropriate in predicting or determining the *clinical* efficacy of an intervention.

In Chapter 1, when I laid out the scientific base on mental illnesses and substance abuse disorders, I did so by invoking other texts as evidence and as expert. To establish mental illnesses and substance abuse disorders as a public policy problem, the magnitude of the problem must be established. The editors of the Surgeon General's report established the magnitude of the problem through the invocation of epidemiological studies that first establish prevalence, then discuss the incidence of disorders, and finally examine treatment options. To talk of the prevalence of X and treatment(s) for Y requires technical vocabularies.

Mehan (1983, p. 208) asserts that there is a "certain mystique in the use of technical vocabulary," that it "indicates a superior status and a special knowledge." The intent of the authors of the DSM-IV were modest, in that they developed "a pragmatic,

common sense system that will help clinical practice and facilitate further research advances" (Frances et al., 1989). I suggest that it is through the use of the technical language of science and specialized training that "expert" status is awarded to studies which correlate prevalence of disorders to burden of disease. Further, I suggest that the naming of disorders is accepted when viewed in terms of the authority that is presented in terms of its presentation. We see this in the *DSM-IV* as diagnostic standard. Its authority is not only supported by the *DSM Sourcebook*, but documented the co-construction of disorders across hundreds of researchers, clinicians, and practitioners deemed expert by their participation in the process. However, like the *DSM*, the many voices in the *Report* also come across as a single voice within a single text. I explore this further in the next section.

Creating a Single Expert Voice

As Gunnarsson (1997, p. 139) remarks in her analysis of spoken and written discourse by communication communities , "Written texts for specific purposes are produced in the same settings and by the same groups of people as is spoken discourse for specific purposes, and the written and oral communication are interrelated." Shared knowledge and attitudes shape the culture of mental health organizations, which in turns guides their actions, e.g., communicative actions in text and in talk.

With over 185 individuals involved in the construction of the *Report*, the institutionalization of these messages is evident in the final product. All chapters are similar in structure. Each chapter contains a literature review that defines its recommendations and continues the Report's primary messages: mental disorders are health conditions and that mental health treatments are effective. The eight

recommendations of the *Report* are woven into each of the chapters: build the science base, overcome stigma, improve public awareness of effective treatment, improve service delivery, ensure state-of-the-art treatments, reduce treatment disparities, facilitate entry into treatment, and reduce financial barriers.

Authority, expert, and evidence are framed certain ways in texts such as reports. Mehan (1983, p. 188) suggests such reports "seem[s] to present decisions rather than debate them." Statements, such as "the research indicates" or "NIMH has found," suggest that these actions are actually "taken for granted" processes, which need no acknowledgement as to the origins of said statements (Smith, 2001, p. 168). These types of texts nominalize organizations and institutions and their existence by mediating, regulating, and authorizing the activities of the reader (Smith, 2001). "Nominalization" means that a verb is made to function as a noun. In so doing, it suppresses the presence of a subject. "Things are getting done, but no one is present to do them," writes Smith (2005, p. 111). In addition, nominalization decontextualizes the event, making an "abstract noun capable of functioning as an agent" (Smith, 1990, p. 44). Texts as agents play many roles simultaneously.

Although written as a traditional research report with a specific intent to inform public health policy, the *Report* is also a primer for those persons not privy to the world of mental health research and service. In addition, it serves as an aggregation of professional and lay voices within mental health. By doing so, it offers both the "inexpert" and the expert an avenue into the discourse of the expert (Excerpt 4.2).

Data Excerpt 4.2.

Overview of Chapter 2

> Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions (US DHHS, 1999, p.14).

Although the text is a primer, it is not "dumbed down" as are so many scientific texts written for the layperson. The *Report* promises the reader that it is factual and wide-ranging, as "its depth of discussion supports a range of conclusions" (USDHHS, 1999, p. 14). By including information geared to professional and lay communities, the *Report* may act as a bridge between them. Linnell (1998), after all, reminds us that all texts contain bits and pieces of prior contextual discourses. Note that the text encourages and invites the lay reader to read at least *this* one chapter written especially for him or her. After finishing the chapter, the reader is encouraged to take action, read more, reflect on the discussion, and take the conclusions as actionable. Note that the *Report's* principal recommendation "to the American people is to seek help if you have a mental health problem or think you have symptoms of a mental disorder" (USDHHS, 1999, p. 21). The *Report* continues with 8 additional actions, two of which a layperson could perform: 1) engage in efforts to overcome the stigma of mental illnesses and 2) improve public awareness of effective treatment (USDHHS, 1999, pp. 22-23). The research in the *Report* can be used as evidence in the reader's performance of these actions.

Over 185 individuals actually worked on creating this document. They are visible in the Acknowledgements section of the *Report* (Excerpt 4.3). The *Report* acknowledges first in its list as expert and authoritative the institutional voices behind its creation.

Data Excerpt 4.3.

Acknowledgements

> This report was prepared by the Department of Health and Human Services under the direction of the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, in partnership with the National Institute of Mental Health, National Institutes of Health (USDHHS, 1999, p. 7).

Nine pages later, the acknowledgements end, after thanking individuals and organizations who acted in various roles: editors, section editors, senior science writer, science writers, planning board, and the participants in developing the report. They, and the other voices in the text, that is, the authors of the cited works, speak as one voice, as one authority – not individuals as authors but author as corporate body, the text.

A corporate body is traditionally defined as an organization or a group of persons that is identified by a particular name and that acts, or may act, as an entity. Cooren (2004) suggests that texts, as entities, also act as corporate bodies. Note the actions the text performs. The *Report* "makes evident," the *Report* "lays down a challenge" (USDHHS, 1999, pp. [iv-vi]. The exhortation by the *Report* to seek treatment on page 21 is reiterated on p. 453: "the single, explicit recommendation of the report is to seek help if you have a mental health problem or think you have symptoms of a mental disorder" (p. 453). However, its active role as agent is balanced against its role as expert. Note that the *Report* affirms its corporate identity as scientific expert with its emphasis on use of the third person and passive, not active, syntax (Cooren, 2004) in its claims that mental disorders are health conditions and that mental health treatments are effective.

By accounting for the state of the scientific enterprise as a corporate activity by an institutional (corporate) body, the *Report* can be conceived in terms of a professional report. As Mehan (1983, p. 187) reminds us, a professional report is "embedded in the

institutional trappings of the formal proceedings of the committee meeting" and is assembled in such a way that "decisions are presented, not discussed; credentialed, not negotiated." That is how it "gains its status and authority" (Mehan, 1983, p. 187). Unlike many other professional reports of its kind which are obscure and difficult to understand (Mehan, 1983), the *Report* opted to describe its empirical evidence, its science base, as clearly as possible. Further, it is consistent in its message and recommendations to professionals and laypersons.

Smith (1987, 1999) points out that discourses, particularly those encoded in texts, are important access points for uncovering relationships among participants. Hence, the *Report* is more than just a professional report. It acknowledges the role persons with mental illnesses and their family members play in policymaking. Note how the statement on the importance of the consumer movement and the emphasis on recovery give credence and viability to the "lived experience" as expert knowledge: "The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come" (US DHHS, 1999, p. 14). By acknowledging the consumer and family movement, the *Report* establishes the consumer and family movement at the policy table. Smith (1992, p. 92) argues,

> The idea is not to reenact the theory/practice split and opt for practice, but to locate the knower in a lived world in which both theory and practice go on, in which theory is itself a practice, and in which the divide between the two can itself be brought under examination.

In Secretary Shalala's preface to the *Report*, she notes that consumers and others comprise the "leaders in the mental health field - fiercely dedicated advocates, scientists,

government officials, and consumers" (USDHHS, 1999, p. [ii]). However, to change the "attitudes, fear, and misunderstanding" surrounding mental illnesses and substance abuse disorders, "it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness" (USDHHS, 1999, p. [ii]). Note this is addressed more fully in the final paragraph of the *Report.*

Data Excerpt 4.4.

The Importance of the Consumer

> The journey ahead must firmly establish mental health as a cornerstone of health: place mental illness treatment in the mainstream of health care services; and ensure consumers of mental health services access to respectful, evidenced-based, and reimbursable care (USDHHS, 1999, p. 458).

The *Report* emphasizes the importance of the consumer and family member movements as important mechanisms to bring their concerns and suggestions to the attention of providers, researchers, and policymakers. It is introduced in Chapter 1, with a fuller overview provided in Chapter 2. Its role in changing the delivery of services to in children, adults, and older adults is addressed in Chapters 3, 4 and 5. Consumer and family concerns emerge in the financing of care and in the protection of health information. As mentioned earlier, reducing the stigma of mental illnesses and substance abuse disorders will allow more people to seek treatment and to improve the overall health of the nation. Persons with mental illnesses and substance abuse disorders and their family members are not only a key population, they are the key to improving mental health.

The *Report* brought many voices together and spoke as a single voice, with a consistent message. Smith (1992, p. 92) asserts that a material object "brings into actual contexts of reading a fixed form of meaning that can be and may be read in many other

settings by many other people at the same time or at other times." How the *Report* was used by other communities and to what end is discussed in the next section.

Text as Evidence

The *Report* was the primary evidence provided in the "Mental Health: The State of the Science" Commission meeting. From a Local-Public and the Distant-Public group perspective (Gunnarsson, 1997), the *Report* engaged persons within the local public sector mental health services delivery communities as service providers, as recipients of care, and as advocates. Administrators, managers, and clinicians recontextualized the *Report's* recommendations, especially those regarding recovery, into local practice, restated and referenced in internal documents, and utilized in external documents to other practitioners, providers, and policymakers. From a Distant-Private perspective (Gunnarsson, 1997), which also takes a temporal approach as to future discourses, the *Report* is mentioned in numerous successful Commissions and workgroups addressing public mental health services since its publication. The *Report* is still used as a foundational document in more current national mental health and health initiatives, such as the President's New Freedom Commission on Mental Health (2003) and Healthy People 2020, both of which echo the recommendations of the *Report.*

State and federal commissions and agencies use the *Report* as expert in their own policy work to substantiate subsequent changes to their services delivery. Recipients of care, actively engaged in peer settings and in advocacy organizations, such as NAMI, use the *Report*'s emphasis on the importance of consumer groups as advantage to gain a seat at policy and practice tables, as well as to substantiate their own documents, which they disseminate through print and online media. The use of town meetings establishes speech

contact between members of distant communities and certainly, the internet and social media make access to written and spoken language easier. The inclusion of the *Report* as the central document for the Commission as evidence of what works in mental health services delivery shows how voices in text become testimony. Voices entextualized in federal documents provide context and opportunity for readers to disembed the talk and use such as testimony in other settings, as in the examination of what makes a speaker expert to his or her audience. Take, for example, *Achieving the Promise*, the President's New Freedom Commission (2003) report on mental health released. Written five years after the *Report*, *Achieving the Promise* acknowledges the *Report* as an expert review of the nation's knowledge of its "scientific advances in our understanding of mental health and mental illnesses (New Freedom Commission, 2003, p. 2). With this acknowledgement as expert, the New Freedom Commission did not have to recreate the empirical scientific and literature review of the *Report.* More recently, in 2012, the *Report* is cited for recommendation for community-based care in an Institute of Medicine report.

Constructing the Expert Voice

As I reviewed in Chapter 1 of my dissertation, the use of research-based knowledge was considered best practice in policymaking and policy analysis (Davis & Salasin, 1975; Weiss 1979). Systematic literature searches, quantitative meta-analyses, critical appraisals, and detailed documentation link scientific evidence to clinical conclusions. However, mental health services research requires a more complex organizational perspective. When combined with personal, professional, and institutional

values, knowledge, and beliefs in decision-making, there are challenges and limits to the use of such knowledge as the sole argument to effect change.

Research in policymaking is unlike scientific research, in that it is not "research for the sake of research." A different process is used when policymakers request mental health services research and analysis to fill an acknowledged gap in their own knowledge. Policymakers first identify the knowledge gap; then, they acquire services research, often in the form of expert witnesses. Their next step is to interpret the research in the context of the policy decision. Last, they make their choice of policy alternatives (Weiss 1979). However, knowledge and beliefs are contingent and contextual. Analysts must integrate information in such a way to make sense to policymakers. Policymakers must integrate the analyses into "past experiences in a reasonably coherent fashion" to create future policy (Giddens 1991, p. 215). Considering the complexity of the "de facto" mental health services system, understanding the provision of mental health services may be a series of back and forth interactions among a variety of sources.

"Professions," as Berkenkotter (2001) suggests, "are organized by genre systems and their work is carried out through genre systems" (p. 327), allowing us to explicate specific discursive practices in the context of interrelated genres. Studying these discursive practices allows us to "bridge the macrolevel perspectives of the social structure as shaping and determining human activity … and the micro-level perspectives of situated, everyday practices as constitutive of social structure" (Berkenkotter, 2001, p. 328). With its use of over 3,000 research studies conducted by professionals across multiple disciplines and over 185 individuals who contributed their professional knowledge and lived experience to the *Report*, who can speak for the many expert voices

speaking as one expert in the *Report*? Who is better to make sense of a *Report* than its senior editor Howard Goldman?

The Professional as Expert

A prominent name in mental health services research prior to the *Report*, Dr. Goldman received his MD and MPH degrees from Harvard University and his PhD from Brandeis. He was an editor of *Psychiatric Services* (formerly *Hospital & Community Psychiatry*), published by the American Psychiatric Association, which is one of the top three ranked journals in health services research. As such, the Commission extended an invitation for him to speak about the *Report*. In Data Excerpt 4.5, I examine how David Shern constructed Dr. Goldman as expert.

Data Excerpt 4.5.

David Shern, Business Meeting, 27 February 1999

David: And actually, as you can't see, but I think as all of you are aware, that will be followed by an hour presentation approximately by Dr. Howard Goldman. And, again, I'll tell you a little more about Dr. Goldman in a few minutes. And then we have an opportunity for open discussion and questions about really about the implications of the report for the Florida Mental Health System. And, as I talk about Howard, you'll see he's not only is he distinguished by being the senior scientific editor for the report but he really has a very rich and varied background in terms of public mental health systems and persons with chronic mental illness. He's an extraordinary resource. So, after we talk about the report, we'll perhaps have an opportunity to chat with Howard about some of his other perspectives and feelings about the public mental health system and the role the evolving role of systems to protect the public's mental health. So, that'll be the agenda for this evening. Tomorrow, we're going to focus on testimony around implications for the Florida Mental Health System relative to the Surgeon General's report, have open testimony.

Commission Chair David Shern begins the Sunday business meeting by describing the agenda. After the general business meeting, the Commissioners will meet Dr. Howard Goldman, senior scientific editor of the recently released Surgeon General's report on mental health, and an expert on mental health (lines 38-40).

The agenda for this meeting is built around Dr. Goldman. At the November meeting, the notes from the meeting show consensus from the Commission to bring in Howard to speak. To bring in such an expert as Howard requires more than just a standard "dog and pony" show; it requires engagement and interaction. David is asking the members of the Commission to see Surgeon General's report and Howard as evidence and expert. To do so requires the Commission to choose to adopt the specific ideology of the *Report* (Lines 50-51). David must frame the discussion appropriately.

A frame can be seen as a metacommunicative device that sets parameters for what occurs during an event, that is, "what is going on" construction of a speech act (Goffman, 1974). Frames can be crafted deliberately to resonate with shared beliefs and experiences of potential supporters. Frames also become important in analyzing collective action as individuals channel individual behaviors into a group behavior or in deciding whether an individual is what he or she appears to be (Goffman, 1974). An ideology, as Fairclough (1995, p. 110) reminds us, is a particular choice among available options. Ideologies are explicit when they need to be legitimated, such as to substantiate the need for change and subsequent recommendations for government programs.

Although ideologies and frames are related concepts, of course, each points to different dimensions of social construction. Very simply put, framing points to process, while ideology points to content. If the Commission adopts the *Report* as evidence and

expert, then they need to have a thorough grounding in the "why" they should decide. David must effectively frame Howard and the *Report.*

Frames can be powerful yet unobtrusive persuaders. David begins his legitimation of Howard as "expert" with claims of authority, establishing Howard's credentials. Since David is speaking to a diverse group of discourse communities, he must use a number of different strategies to convince all the members of the Commission. One of the first frames is creating solidarity with the Commission through the use of the pronouns *I* and *you* in line 41: "As I talk about Howard, you'll see." Sacks (1992, p. 675) points out: "I' is the way I refer to myself in talk and not a substitute for my name." Using the first person singular pronoun has a number of functions. First, "'I' ties the talk to other parts of the talk and indexes the speaker to the here and now" (Sacks 1992, p. 32). Second, it states the speaker's position (Malone, 1997). Third, "I" is used as a means of establishing rapport with the audience, showing a degree of personal involvement and commitment (Wilson, 1990).

David uses *you* as a social resource (Malone, 1997; Sacks, 1992). Sacks (1992, p. 165) argues that an inherent property of "you" is its "this and that ambiguity," in that the listener is always included regardless of whether the "you" is singular, plural, or generic. Further, since "you" is integrally implicated in speaker involvement, it is a useful resource for the speaker to construct an action as a normal or typical activity (Sacks, 1992). Unlike "we," which has the potential to exclude the hearer depending on the intended membership of "we," Sacks (1992) claims that "you" is useful as an inclusive term because it does not exclude the hearer.

Context is an important resource for disambiguating the meaning of "you" (Goffman 1981, Malone 1997, Sacks 1992). Similar to the use of "you know" to indicate a shared identity (Schiffrin, 1987), David's use of "you'll see" is meant to create alignments between David and the Commission regarding Howard and the *Report*. "You'll see" implicates all the Commission members in the action, giving more credibility to the assumption everyone will agree to the expert status of both Howard and ultimately the *Report.* Notice also David's use of the more colloquial contraction *you'll see*, it is not meant as a command, "you *will* see," but more "of course you will see." In his use of pronouns, David is implicit in his expectation that the Commission will come believe this has the same significance as he does.

He ties together the heterogeneity of these claims by using conjunctive "listings" of *and* and *but*. Howard is this *but* he is also this. He will do this *and* he will do that. Howard is "senior scientific editor for the report" (line 42). In the mental health community, this in itself is explicitly and implicitly a most prestigious and powerful position. It is Howard's background, perspectives, and feelings that are significant factors of which the Commission should be aware. David also leverages the legitimacy of the nationally recognized "expert" status of the *Report*, tying it as a way to support the legitimacy of the Commission's analysis (and future report) (lines 40, 50-51).

Evaluation is concerned with the values which people commit themselves (Fairclough, 2003). Evaluation is determined through four values: evaluative statements, deontic (obligational) modality, affective evaluation, and assumed value. Evaluative statements discuss the desirability, importance, or usefulness of a course of action or belief, for example, "this is good." Deontic modality uses words such as *must* and *should*

to imply desirability. Affective evaluation is observed through the use of process verbs, such as "I like X." Assumed values are implicit values. To make an evaluative statement using assumed values indicates there is a shared familiarity with the implicit value system between speaker and audience.

David uses evaluative statements and assumed values to support his claims about Howard. David evaluates Howard as "extraordinary resource" to the Commission. David implies that he and Howard share the same values regarding public sector mental health. David also implies that, since the Commission and he share similar values, they and Howard share similar values. He implies these values will emerge in an active discussion with Howard (lines 39-41). He further implies (lines 46-47) that the discussion has value in the Commission's deliberations on Florida's future but there are important lessons Howard can teach them (lines 48-49).

There is also an issue of identity that emerges in the excerpt. David uses his own expert status to substantiate Howard. At the national level of mental health policymaking, Howard Goldman is a "heavy hitter." David, as Chair of the Commission, is an acknowledged "expert"; his evaluation of Howard carries weight. To have Howard speak to the Commission gives additional credibility and weight to David.

Finally, the use of *we* tracks David's attempts to ensure adoption of Howard and the *Report* as expert. "We" is a marker of category membership (Sacks, 1992) and indicates "institutional identity (Goffman, 1974; Sacks, 1992). Although the core meaning of "we" is collective, "we" is used to achieve a number of actions, depending upon its intended use as singular or plural form.

Equally important is the context of the talk (Drew & Heritage, 1992; Schiffrin 1994) as to the nature of 'we' for the particular action. In lines 39, 45, 46-46, and 49-50, David

uses "we" as an institutional identity, speaking on behalf the Commission as to the intended actions for this meeting: "we have an opportunity" (line 39), "after we talk about the report we'll perhaps have an opportunity to chat" (lines 45-46), and "we're going to focus" (lines 49-50). The repetition of "we" tasks emphasizes that the Commission is sharing responsibility for or benefiting from Howard' future discussion of the *Report*. Two of these are future, actions for the group as a whole, reinforcing group membership and "institutional identity" (Sacks, 1992).

The phrase "we have" is used as a marker of group membership and collective involvement (Sacks, 1992). Similar to "our," "we have" or "we are" is an interactional tool implying that "you" (the Commission) and "I" (David) and everyone else (Howard), are all involved and/or affected by this. It is a discursive strategy to draw everyone into the same group. It constructs a situation in which everyone is involved.

Consider David's statements that Howard Goldman's knowledge of the Report is the primary reason for the evening agenda. David reminds the Commission of the importance of Howard's testimony on the *Report.* The testimony presented at the next day's meeting will be reviewed "relative to the Surgeon General's report" attests to the importance of his role as expert; he will make the 487-page *Report* understandable to the Commission. That he is worth the long day of that day's Commission meeting. I suggest David's claims make explicit the role of expert and evidence of both Howard Goldman as expert in his own right as a professional, as well as Howard Goldman as expert on the expert text, the *Report.*

Although the Commission could learn many things from Howard, professional knowledge is not the only knowledge that is deemed expert in the world of mental health.

In the next section, I examine the construction of another type of expert, one who has the lived experience of being a family member of a person with a serious mental illness.

The Family Member as Expert

It is interesting to note how the Surgeon General's Report emphasizes the expertise brought by consumers, family members, and advocates. The *Report* recontextualizes almost thirty years of the consumer and family movements into its discourse of science. During the 1970s, the families of persons with mental illnesses began to organize as a response to deinstitutionalization and to decrease the stigma associated with mental illness and to improve health at an individual and collective level. In 1979, family members formed the first chapter of what would become the National Alliance on Mental Illness (NAMI), in Madison, Wisconsin (USDHHS, 1999, p. 96). By 1981, the family member movement was gaining national attention (Lefley, 1996). By 1999, the influence of family members showed in the increase of consumer representation on federal and state mental health planning councils. Although the 1963 Community Mental Health Center Act had a provision for citizen participation, later federal laws, particularly the 1986 State Comprehensive Mental Health Plan Act and Public Law 102-321, mandated citizen participation on state and federal mental health planning councils for councils to receive federal funding. The legislative language of House Bill 2003 recognized the importance of the consumer voice by the inclusion of a family member on its membership roster for the Commission. The Commission included both a consumer and a family member in its membership. It further gave weight to the consumer and family member voices through invited and public testimony. In this

section, I examine the voices of Ruth O'Keefe, a family member of a person with a serious mental illness.

Framing, footing, and alignment are ways to examine social roles (Goffman, 1974, 1981). They offer insight on how speakers signal social roles and position themselves vis-à-vis one another during interactions. Frames are mental constructs that shape the way we see the world. Objects or elements within the frame are related to one another vis-à-vis their footing (i.e., where they figuratively stand in relation to the other). There are times where individuals need to shift frames within a social interaction. This is accomplished by shifting their footing, that is, the stance or alignment a speaker takes in relation to another.

It is important to Ruth to get the Commission's attention (Excerpt 4.6, lines 6-7) by whatever means she is able to secure a place on the agenda. Ruth's testimony begins with an acknowledgement of how she uses her professional degrees (JD, MBA, CPA). It has been her experience that people give more credibility to the opinions and experiences of people with credentials. Ruth begins with an apology for being a lawyer, which elicits laughter from the Commission. Laughter helps to create group solidarity and discourse chains that are more collaborative (Coates, 2007). This joke frames Ruth's next activity (Goffman, 1974), as she directly thanks the Commission on undertaking this work. Acknowledgments such as these, following her use of humor, build or scaffold investment in the speaker (Coates. 2007).

Data Excerpt 4.6:

Ruth O'Keefe, Testimony, 28 February 1999

1	Ruth	Thank you very much. Um I apologise for putting my professional
2		credentials on my introduction yet JD MBA CPA I am a lawyer and I
3		apologise for that [laughter] I have an MBA and a CPA also and I
4		apologise for that as April 15th is coming um and those credentials um I
5		have to say I will usually include when I speak as a family member
6		simply because people may attention more to lawyers and CPAS and
7		I'm sorry and I apologize for using those credentials to get me a place
8		on the agenda but nevertheless if they'll work I'll use them.
9		I want to thank you to the Commission. I have not ever worked on such
10		a positively monumental task As I look at your faces today I know it it
11		must be overwhelming. I reviewed the executive summary of the
12		Surgeon's General report and I applaud the effort um
13		unlike Dr. de la Torre, I am able to say that the Surgeon General
14		didn't say one thing that I want to say today so the things that I am going
15		to say are going to be quite different than the statistics that you have
16		been reading so far. My real credentials for being here today are as a
17		family member um it's a f word that a lot of people don't want to deal
18		with. For so many years family members were ignored and our input
19		was not valued at all and I am happy to see that this is currently
20		changing. Um my family members I have two children.

It is important to have the audience "feeling friendly" since her next utterance can be considered oppositional (lines 13-16). This is significant in that Ruth offers an alternative perspective to the expert status of the previous speaker and the Surgeon General. She is shifting the frame, her footing, and the footing of the Commission members to accept a different type of expert. Her real credential is her role as a family member. As stated earlier in the chapter, experts often discredit and ignore credentials when there is a difference in the definition of "expert." For many years, family members were ignored by the other "experts" at the table (Excerpt 4.6 lines 18-19).

Shifts in footing can affect interpersonal alignments, social roles, tasks, status, or social distance. Alignment is any kind of synchronization across participants on the intellectual and/or emotional level, for example, speakers are emotionally but not intellectually aligned (Goffman, 1974, 1981). Although alignment often is used synonymously with agreement, agreement does not necessarily mean real consensus. Sometimes alignment is seen as a type of "pseudo-accord." This may be an issue in interactions where one person is perceived to have a lower status than another. The individual with lower status may have to work harder at projecting alignment in order to make headway in a group.

Even with the weight of the Surgeon General's report as to the value of the consumer and family member voice, she is not sure of her acceptance as expert. The message she brings is different. Although she respects the work accomplished by the Report, she does not agree with the distant public voice of the Surgeon General (Excerpt 4.6 lines 11-13). His report is but one voice, and that voice is not hers. Not only did the Surgeon General not say the things she wanted people to know about, O'Keefe's story is not about science, i.e., "facts as evidence."

Ruth's choice of narrative provides two types of accounts. At a macro-level, Ruth shares her identity within the community of family members with the Commission; at a micro-level, it is a metadiscursive strategy, which achieves persuasive objectives through the establishing of the speaker identity in relation to the hearer. Like David's discussion above, Ruth's choice of a narrative uses the first person singular pronoun to accomplish a number of functions.

Data Excerpt 4.7.

Ruth O'Keefe, Testimony, 28 February 1999

39 Ruth: with my younger son has been more difficult. But with those credentials
40 in mind I do want to say that what I do now as a volunteer and I'm not
41 being paid to speak here and the main thing that I do that I think is my
42 best work is not the work I do at Jacksonville University I am proud of
43 that too but as an advocate and someone who tells it like it is from the
44 family member's perspective um I volunteer with the local Alliance for

In addition to indexing and positioning the speaker (Malone, 1997; Sacks, 1992), it shows Ruth's level of personal involvement and commitment (Wilson, 1990). Note also her use of the conjunction *but* to tie together the disparate worlds of professional academic and advocate. She is proud of both worlds of which she is a member (Excerpt 4.7 lines 42-43). Her story is tacit knowledge as fact, i.e., the effects mental illness has had on her children, her family. She has lived it as a parent, an advocate, and as a professional.

This day O'Keefe is speaking to a Commission, comprised of a range of mental health professionals and a family member. Hyland (2005, p. 141) observes, "community constraints on discourse both restrict how something can be said and authorize the writer as someone competent to say it." To further establish her credentials with the Commission, O'Keefe invokes her expert status as family member through her association with the National Alliance for the Mentally Ill (NAMI). In the Surgeon General's *Report*, NAMI is acknowledged as a major contributor and player in the public mental health sector, particularly at the federal level. NAMI successfully lobbied for Federal legislation for family membership in state mental health planning boards (e.g., Public Law 102-321) and for increased Federal research funding. NAMI is "a powerful

voice for the expansion of community-based services to fulfill the vision of the community support reform movement" and is "a prime force behind congressional legislation for parity in the financing of mental health services" (USDHHS, 1999, p. 96).

Data Excerpt 4.8.

Ruth O'Keefe, Testimony, 28 February 1999

44	Ruth	family member's perspective um I volunteer with the local Alliance for
45		the Mentally Ill which is a lifesaver to me and also teach the family to
46		family education course developed by Dr. George Burland that is
47		sponsored by the National Alliance for the Mentally Ill I am one of the
48		trainers for the state of Florida who trains other teachers to teach family
49		members it's a twelve week course on how as a family member to deal
50		with the trauma of the medical condition and the fallout from the
51		mental illness and I am very proud of but humbled by the work that I do
52		I have to thank Jo Heller also for inviting me to be a representative of
53		the family members uh she tells me that I was the unanimous choice
54		knowing how territorial we all are and I'm sure the Commission has
55		some idea about that too uh it's a major miracle that they agreed and
56		possibly it's because of the official credentials that I have.

O'Keefe is credentialed to teach NAMI's Family-To-Family education program that trains teachers on how family members to handle the trauma and fallout of mental illness (Extract 4.8, lines 48-49). Further, NAMI, who has constructed its own discourse on who is expert, officially has given O'Keefe its proxy to be its "expert" at the Commission meeting (Extract 4.8, lines 52-53). She explicitly thanks Jo Heller, a strategic move which shows both Jo's status and her own status within NAMI. Humor is used again, in lines 54-56, as Ruth makes an inside joke about miracles and territory. This also is an attempt at alignment. In lines 54-55, Ruth implies that she and the Commission members

enjoy a shared knowledge about the political natures of the advocacy communities. The use of "I'm sure" indicates certainty on Ruth's part this statement is true.

O'Keefe now can ventriloquize other experts (Cooren, 2010) in the sense that she speaks for others with several expert voices. She speaks professionally as one credentialed to be taken seriously both in her academic credentials but also within NAMI. She speaks not only as an expert on handling mental illness as her role as mother of a child with chronic paranoid schizophrenia but also as a parent teaching other parents. Finally, she represents NAMI as chosen by her peers (Data Extract 4.8, lines 53-53). This is important. O'Keefe "speaks" for NAMI, an organization with its own clear identity as a "mental illness" group directed by parents and relatives of people suffering from mental illness. NAMI has its own institutional discourse and identity, both of which have clearly established expectations for peer relationships with mental health staff, professionals, and policymakers. She embodies and materializes other collectivities in her speech.

Each of her credentials provides an accompanying identity. She is able to move at ease through numerous discourses, although her preferred discourse is as family member of a person with mental illness. It is in this identity that she integrates the resources afforded to her by her academic and professional identities as well as the resources of the consumer movement while playing by the rules of the policymaking setting. She negotiates meaning for the Commission, shifting the dominant cultural conception of illness away from "victim of disease" to action. Her testimony illustrates her hope that her voice, representing many other "expert" voices, can effect necessary changes in the delivery of mental health services, for the sake of all families coping with

mental illnesses. This provides an added dimension on the construct of expert voice as well as the notion of constructed discourse in which stakeholders interpret talk and texts to suit their understanding of the world.

Summary and Conclusion

Numerous factors play a role in the construction of expert. Nowhere is that more evident than in the public policymaking arena. To participate, an expert must show authority and be "legitimated" with the appropriate credentials. In this chapter, I have shown how *who* is the expert and *what* is evidence are defined. Within the academy, there are levels of expert and evidence. Expert is associated with knowledge that is theory-based, often abstract and generalized, and scientifically constructed. Explicit knowledge frames expert knowledge, with codified theories, rules, and procedure (Yanow, 2003). Local knowledge is practice-based, context-specific, and interactively derived among the participants (Yanow, 2003). Unlike expert knowledge, which focuses on learned information from technical and professional disciplines, local knowledge is lived and experience-based. It is also tacit, i.e., practical knowledge without being codified.

Earlier in the chapter, I wrote that the purpose of the Office of the Surgeon General is to use science as evidence to support the health of the nation. To accomplish that task, the *Report* must provide an accurate and comprehensive accounting of the debilitating effects that untreated mental illnesses and substance abuse disorders have on the overall health of the nation. This requires the *Report* to speak for those who can and cannot speak for themselves. However, it must speak as one voice, as an expert voice, with evidence that can withstand scrutiny by public and private audiences, at a distance

and locally, in 1999 and into the future. To do that, it must determine what claims are evidentiary.

I show how expert discourses create expert as text and the agency such discourses provide. Consider that the Surgeon General's report was considered "expert" by expert professionals and academics in mental health and substance abuse. The *Report* gave weight and authority to the value of explicit (scientific) and implicit (experiential) knowledge as expert. House Bill 2003 acknowledged key, expert communities in its roster of Commission members. The Commission accepted the value of explicit and implicit knowledge with its selection of expert and invited testimony, and with the hours devoted to public testimony at each of its meetings. The *Report* made recommendations that are still relevant policy discussions today. The *Report* took professional and lay discourses and merged them into a single consistent message: mental illnesses can be successfully treated. I suggest the *Report* speaks not only for the consumer and family member but also for the professional.

Both professionals and family members spoke in the production of the *Report*. David Shern saw the *Report* and Howard Goldman's interpretation of it as central to the Commission's framing of what services delivery might be in Florida. Ruth O'Keefe saw value in the *Report* but *her* voice was missing. The lack of consumer and family narratives in the *Report* did not share the reality of her world and her life. Her story, as related to the Commission, extended the consumer and family member voice held within the *Report.*

Consider also the construction of expert through credentials. Goldman has academic credentials (MD, MPH, and PhD); he has professional credentials (senior

science editor of the *Report*), and he has peer credentials (Editor of *Psychiatric Services*). O'Keefe has academic credentials (MBA), she has professional credentials (CPA, JD), she has family member credentials (NAMI), and she has peer credentials (NAMI members).

By constructing a topic as discourse, Potter (2003, p. 785) argues the speaker "marks a move from considering language as an abstract system of terms to considering talk and texts as social practices." Ruth is not reporting her life as a family member only as a sympathetic event. Her account is constructive and action-oriented. It is constructive in that it offers a different version of mental illness from a very specific perspective, that of a mother with a son with serious mental illness. It is also action-oriented in that it shows the actions she and the system have taken on her child's behalf. Ruth's account provides a factual discourse in which she manages causality, agency, and accountability in mental health services and makes it relevant in talk (Potter, 1996). Wetherell and Potter (1992) remind us that everyday language practices reproduce and legitimate relations of power. Ruth's narrative attempts to provide address the contradictory and ambivalent nature of everyday sense-making practices around the stigma and treatment of mental illnesses.

Recognizing appropriate evidence is critical in policymaking, in academia, and in the public. I offer that evidence is more than formal research quantitative data, health services date, or empirical and clinical data. Evidence can support policy, it can undermine policy; however, evidence, on its own merits, will never result in policy. Evidence can make an important contribution to policymaking but it must be used within the context of meaningful policy objectives and the data must support those objectives.

Bartesaghi and Castor (2008) remind us, "the work of social construction is most fruitful when it can contextualize microanalysis within social and institutional asymmetries." I suggest the *Report* itself establishes the social construction of evidence and expert (i.e., the science base) in mental health. Chapter 1 asks the questions, "What do we know about the state-of-the-science in mental health? And how do we know it?" Bartesaghi & Castor (2008, p. 226) remind us, "Social construction is a questioning process." Each text begins with a research question. These texts and the activities by which they were created show the constitutive and constructive aspects of communicating "evidence" and "expert." After all, constructing knowledge is a "relational process" (Bartesaghi & Castor, 2008, p. 226). Note the hundreds of people involved in the reconstruction of the *DMS-III* to the *DSM-IV*. Consider over 185 individuals are named as authors in the construction of the *Report*. Both texts required the communicative chain of text and talk to ensure the construction of expert.

The *Report* is "constitutive and consequential" (Bartesaghi & Castor, 2008, p. 226). Together, each community, comprised of diverse individuals and disciplines, pulled together data to document the scientific knowledge produced before and during the Decade of the Brain. These individuals, groups, and institutions put "forth a realistic notion of reality" (Bartesaghi & Castor, 2008, p. 226), documenting their understanding of the current scientific knowledge of mental illnesses and substance abuse disorders. Further, their "[d]iscourse is material and embodied" (Bartesaghi & Castor, 2008, p. 226). The texts are tangible; they are printed, reproduced, cited, studied, and quoted. Further, they are entextualized and recontextualized in numerous other texts over distances and through time. The texts explain what they did, why they did it, and how

they did it. Most importantly, the *Report* provides an accounting of its work and the work of many communities involved in the world of mental health. Hence, it is "a practical and therefore socially accountable process" (Bartesaghi & Castor, 2008, p. 226).

Consider the number of voices heard in the texts used in this paper. During the creation of the Surgeon General's report and the Commission's reports, the federal and state governments drew upon a range of knowledge from many shareholders. There were a number of expert communities from which evidence, in the form of data and testimony, was solicited, listened to, read, discussed, and institutionalized across many media.

Although we may not have been present at the actual meetings of the Commission, there are streamed videos of the Commission meetings that we can pull up and review. Although we may not have been participants in the note taking at the business meetings, invited expert meetings, or public testimony, there are formal documents for review and comparison to the videos of these events. Close review of these texts allow us to see the sense-making process of public policymaking not as a single event but as a communicative chain of text and talk in the use of evidence and the construction of "expert."

Instead of analyzing discourse for grand theories, Arts and Tatenhove (2004, p. 340) suggest instead that "we theorise about 'small stories', discourses, different interpretations of phenomena, fluid processes, the changing and multiple identities of actors and the social construction of 'facts'." In Chapter 5, I examine how expert and evidence were used in the construction of the interim and final reports of the Commission.

CHAPTER FIVE: AGENCY AND RECONTEXTUALIZATION IN PUBLIC POLICY TEXTS

> Communication situations do not occur in splendid Isolation. On the contrary, they are connected in countless and subtle ways, across space and time, through artefacts (such as written texts and Computer files) and human beings who wander between situations. This means that also discourse and discursive content will travel across situations. Let us call this ubiquitous phenomenon "recontextualisation" (Linell, 1998, p. 144).

Public policy documents are not cast in stone. Although the talk surrounding a public policy issue is objectified in text, Linnell (1998) reminds us that the text is recontextualized. The text is interpreted and placed into context by its readers, who belong to numerous communication communities and utilize a number of communication genres. These communication communities utilize specific genres to create a chain of text and talk (Gunnarsson, 1997). These texts, which are seen as expert and evidentiary, often are imbued with agency by their authors to mandate, evaluate, and recommend actions (Cooren, 2006).

This chapter builds upon the work done in Chapters 3 and 4, where I show the communicative chain linking text and talk and how a text is given the status of expert and evidentiary and authority, as it requires actions from its readers. In this chapter, I explore how the agency of House Bill 2003 influenced the products and process of the

Commission with an emphasis on entextualization and recontextualization. I examine how the products of the Commission -- its Workgroup reports and the Final Report -- were written. As the Interim Report was crafted by Commission Chair David Shern and Executive Director Nancy Bell for review by the Commission members, so were the Workgroup and Final reports crafted by additional authors for review by the Commission members. However, none of these documents would have been written if it had not been for the agency of the legislative text, which called the Commission into being. I show how each document was written for a specific audience, within specific institutional structures, and how each was influenced and adapted to a specific set of norms, attitudes, and values. I also show how the talk generated by the Commission and testimony by public stakeholders were reframed into a specific discourse that would result in the generation of texts and textual agency.

The Importance of Texts

How important are texts? Although public policy texts are considered important documents, they are not immutable. Public policy texts undergo changes and modification through entextualization and recontextualization. Entextualization shows how text and talk is situated. We see entextualization in analyses and evaluations of these reports. For example, there were numerous commentaries written after the publication of the Surgeon General's report. These commentaries range across different communities, from academic (Jones, 2000), practice (Preboth, 2000), and policy (Hegner, 2000). Each reader provided an interpretation based upon his or her contextual understanding of the Surgeon General's report, resulting in an authored text that had a particular resonance toward his or her community. Recontextualization shows how

meaning is created across time and space. *Mental health: a report of the Surgeon General* generated numerous policy meetings, conferences, and texts. Each of these actions referenced *Mental health* as its foundational text, as evidence, or as expert in its own arguments (e.g., Office of the Surgeon General, 2000, 2001a, 2001b; *Healthy People* initiatives).

Linnell (1998, p. 149) offers two approaches by which to study the recontextualization of texts. The first approach is to show the intertextual chains; the second approach is to study the "multi-voiced mix" within single texts. Texts are not passive repositories or accountings of the work of a group. Just as individuals, groups, and institutions have agency, so do texts. Austin (1962) observed that we "do" things with words. Gibson (1979) asserts objects afford certain behaviors on our part; hence, it is critical we recognize and understand how we interact with these objects. Locke and Golden-Biddle (1997) suggest the social construction of scientific knowledge affords active agency to texts.

Latour (2002) stresses the importance of examining "what does the explaining" (explanans) and the "what needs to be explained" (expandandum) using both human and non-human entities (objects), e.g., the social interaction between individuals or between humans and artefacts, such as texts. Cooren and colleagues (2006, p. 534) suggest both human and non-human entities help us account for how "the world as we know it is structured and organized" because "objects *do things*" (p. 535, italics in original).

Not only do non-human entities, such as texts, contribute to human social and organizational processes, they themselves are attributed agency. For the purposes of this discussion, I use the following definition of agency: "the capacity to make a difference,

that is, to produce some kind of change/transformation in the chain of actions" (Cooren et al., 2006, p. 539). Further, this action can be attributed to individual, group, or institutional actors identified in the intertwining of the chains of text and talk through the identification of discursive and genre strategies. This agency exists in legislation, as shown in Chapter 3 where I examined the agency of a bill as it moves through the House of Representatives, as well as in Chapter 4, where a text, *Mental health: A report of the Surgeon General,* speaks for the nation. To explore further the agency of a text to invoke other texts and actions in public policymaking, I examine how House Bill (HB) 2003 invokes statutory authority.

The Originating Text: Legislation and Statutes

My data are the Statutes and Laws of Florida. Florida Statutes are a permanent collection of state laws organized by subject area into a code made up of titles, chapters, parts, and sections. The Florida Statutes are updated annually by laws that create, amend, transfer, or repeal statutory material. The Laws of Florida are a compilation of all the laws, resolutions, and memorials passed during a legislative session.

In 1999, House Bill 2003 formally noted the Legislature's identification of a public policy issue, specifically, that "major changes and improvements have occurred in how mental health and substance abuse services are planned, purchased, delivered, and accounted for" (HB 2003, 1999, lines 5-16, p. 5). Further, "the management of the state-supported mental health and substance abuse system has not kept paces with improvements in the field, thereby diminishing the potential efficacy of its investment in mental health services and substance abuse services (HB 2003, 1999, lines 5-16, p. 5). HB 2003 addresses a larger systemic concern, "the management of the state's substance

abuse and mental health service system delineated in part IV of Chapter 394 Florida Statutes has not been systematically reviewed and updated in over 15 years" (HB 2003, 1999, lines 5-16, p. 5). Hence, the Legislature requires "a systematic review of the overall management of the state's mental health and substance abuse system be conducted and that recommendations for updating part IV of Chapter 394, Florida Statutes, and other related statutes be formulated" (HB 2003, 1999, lines 16-20, p. 5).

In the next 153 lines of HB 2003 as enrolled, the Legislature ascribed to the Commission its "home" within state government (the Department of Children and Families), the scope of its duties, who would be members of the Commission, who would comprise its advisory committees, who would provide staff services and supports, its meeting schedules and deliverables. HB 2003 required the Department of Children and Families to appoint an Executive Director and to provide administrative and clerical support. It also required the Commission to coordinate its activities with the Office of Drug Control within the Executive Office of the Governor. Although the text of HB 2003 identified a public policy issue and requested a series of actions to be performed by an entity to be created, HB 2003 has simply contextualized an issue that needs to be examined, evaluated, and corrected. It has "talked into being" (Heritage, 1984, p. 283) a public policy problem and created a vehicle to resolve the problem: the Commission.

However, HB 2003 is not considered a concrete text (Kuhn, 2008) until it is reviewed by the Governor. Since the Governor has veto power over all legislation brought to him, his sanction gives HB 2003 its weight and relative permanence. Further, HB 2003, as enrolled and signed into being, brings with it certain contexts and anticipated actions of the Commission and its legislatively mandated supports and

reporting. As concretized in Chapter 99-396 Laws of Florida, the Commission on Mental Health and Substance Abuse formally received its task.

Gunnarsson (1997) suggests it is through the intertwining of the genres of text and talk we can trace the chaining of activities conducted and to be performed in the day-to-day decision-making of a public sector agency. I would add that legislative texts, such as HB 2003, are designed to be "an agent acting for a principal" (Cooren, 2010, p. 30). The Commission is directed to review and evaluate "the management and functioning of the existing publicly supported mental health and substance abuse systems and services in the Department of Children and Family Services, the Agency for Health Care Administration, and all other departments which administer mental health and substance abuse services" (HB 2003, 1999, lines 26-31, p. 6). The directive includes an emphasis on priority population groups, emergency behavioral health care systems, and the clinical workforce (HB2003, 1999, lines 8-29, p. 7).

HB 2003 invokes other texts, specifically statutory authority, when it enjoins the Commission to review and evaluate actions of the ten state agencies and departments that provide mental health and substance abuse services. The Commission will conduct "at a minimum, a review of current goals and objectives, current planning, services strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms" (HB 2003, lines 1-5, p. 7). HB 2003 implicitly directs the Commission to a number of other texts that are objectified in the Florida Statutes (FS).

Chapter 216.013 F.S. requires all state agencies to develop long-range program plans. These texts provide an accounting of the work and the intent of the agency or

department to provide services to specific populations as mandated by state and/or federal requirements. At a minimum, the Commission would review the strategic plans of each of the ten agencies and departments formally identified as providing services. However, purchasing, contracting, financing, and local government funding responsibility are found in the texts of agency and departmental budgets, the state budget as approved by the Legislature, and in mandated reports to federal funding agencies.

Although strategic plans show accountability by claiming specific accomplishments completed in previous years, accountability for state agencies and departments is found in the justification reviews conducted by the Office of Program Policy Analysis and Government Accountability (OPPAGA) housed in the State Legislature. Its authority found in Chapter 94-249 Laws of Florida, OPPAGA assesses agency performance measures and standards, evaluates program performance, and identifies policy alternatives for improving services and reducing costs. Each OPPAGA review requires a formal response by the head of the agency or department under review.

In addition to the strategic plans, budgets, and justification reviews, other seminal texts include statutes, administrative codes, and legislative histories. Any recommendations made by the Commission must assess possible impact on these existing texts and the agency each text exerts on those entities responsible for the provision of services to persons with mental illnesses and substance use disorders. For the purposes of this discussion, only five chapters of the Florida Statutes are identified. Chapter 394 Florida Statutes (FS) authorizes the publicly funded mental health and substance abuse system and establishes the civil commitment process for persons with mental illnesses (the Baker Act). The 1999 statutory definition of mental illness in the Baker Act

specifically excluded intoxication and substance abuse impairment. Chapter 395 FS covers access to emergency services and care and requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility. Chapter 397 FS (Marchman Act) 1) specifies the procedures for the treatment of alcohol and drug disorders as well as for involuntary and voluntary commitment, and 2) delineates client rights, offender and inmate programs, service coordination, and children's substance abuse services. It also establishes the Office of Drug Control to whom the Commission will report. Chapter 627 FS relates to insurance and health coverage, including disability and mental disorders. Chapter 915 FS authorizes mental health services for persons with criminal charges (not guilty by reason of insanity and incompetent to proceed to trial).

In addition, for each statute that requires action on the part of agencies or individuals or the state, there is a corresponding text in the Florida Administrative Code (FAC) that describes in detail oversight, accountability, procedures, and assessment for a service or a program. Chapter 394, for example, corresponds to 65E, FAC "Mental Health Program"; Chapter 397 FS corresponds to 65D, FAC "Substance Abuse Program."

For a statute to be amended, a legislative analysis of the Florida Statutes is required to determine the extent of the impact of such an amendment. For the Commission to make recommendations means that it must acknowledge, consider, and review the texts that authorize and administer the actions to be performed by individuals, groups, and institutions.

Each of these texts have agency in how the state of Florida and its many agencies (public and private) diagnose mental illnesses and substance abuse disorders, provide services to persons with mental illnesses and substance abuse disorders, and compensate providers of the services. Each text also prescribes specific accounting pathways for the agency to another authority acting for a higher authority within the state. However, the textual agency found in the state agency strategic plans, the FS, and/or the FAC would, in turn, be constrained and or acted upon by federal texts. One such example is the Florida Agency for Health Care Administration (AHCA), which must follow actions laid out in the administrative texts of the federal Health Care Financing Administration (HCFA, now known as the Centers for Medicare and Medicaid), which has approval over disbursement of monies for state programs delivering mental health and substance use disorders services. AHCA also has accountings it must make to OPPAGA, the Governor, the Legislature, and the federal government in the form of texts. All state documents that account for the actions of an agency are "in the sunshine" and available to a larger public audience.

In addition, the Commission elicited public and invited testimony from human experts and numerous objects, i.e., texts in the form of authoritative documents (federal and state documents, government reports, and the academic research literature) in order to make sense of the system it was charged to review and to inform its two deliverables: the interim and final reports. In the next section, I examine the interim and the final report vis-à-vis its actions as proscribed by the legislation and by its own determination.

The Deliverables: Interim and Final Reports

Kaufer and Carley (1993, pp. 126-127) measure the "reach" of a report by who has "received" the document. Gunnarsson (1997) also suggests the "addressee" of the document contributes to its importance. Chapter 99-396 Laws of Florida charged the Commission on Mental Health and Substance Abuse to submit an interim report on its progress by a certain date and a final report offering recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives. These documents would be an accounting of the work of the Commission in carrying out its legislative charge. Such an accounting is more than just reporting. Accounts are routinely provided or demanded to provide "overt explanation in which social actors give accounts of what they are doing in terms of reasons, motives, or causes" (Heritage, 1988, p. 128). Hence, accounting constitutes social action; whether it is in talk or in text. It is the organization of accountability that produces "sense" of what is being accomplished (Giddens, 1976, p. 20). Under Florida's "Sunshine Law," all government accountings are open for public review.

The Interim Report of the Commission

The data for the discussion on the Interim Report comes from the report itself, and from the transcript of the 27 February 2000 meeting of the Florida Commission on Mental Health and Substance Abuse on "Mental Health: The State of the Science."

The Interim Report is an accounting to date of the Commission's activities and findings from its inception in November 1999 to 1 March 2000. It is not only an accounting of what activities it has performed or what it has learned; it is also a potential

accounting of what it will do in the future, as it moves toward the completion of their final report.

The report itself is only four pages long. Its twenty appendices (A to T) contain documents that provide proof of tasks accomplished and of intended future actions. The first two sections – Background and Process of Commission – substantiate that the Commission members were appointed, a chair was elected, an Advisory Committee was created, and an Executive Director hired. These were specific tasks the legislation required. The Process section accounts for the statewide meeting requirement, which it can document as shown in Data Excerpt 5.1.

Data Excerpt 5.1.

Accounting for Its Actions

> The Commission has met monthly in different locations around the state of Florida, with the goal of providing an opportunity for citizens throughout the state to testify before the Commission (FCMHSA, 2000, March 1, p. 1).

The Commission makes the claim it is successful, with 225 participants, 25 instances of invited testimony from identified experts, and 45 instances of public testimony between the December and January meetings. The inclusion of public testimony accounts for the legislative requirement of public participation, and the implicit acknowledgement of the importance of consumer and family members in the process. In Excerpt 5.2, the Commission also accounts for its meeting format.

Further, Commission members were provided with background materials relevant to the themes of those meetings by the Executive Director; they also received printed materials from the invited experts and the public participants. The Commission also accounts that it is meeting its public participation charge in

that the public has access to these background materials through the Commission website. This accounting shows the temporal and spatial aspects of the communication communities and genres among the Commission and public mental health and substance abuse stakeholders shown by Gunnarsson's (1997) matrix of local/distant/private/public communication in Chapter 3.

Data Excerpt 5.2.

Accounting for Its Structure

> a business meeting; a facilitated group discussion of Commission goals and objectives; focused testimony on the day's theme from invited speakers (most from the geographic area where that meeting was held); and open public testimony from members of the community at large (FCMHSA, 2000, March 1, p. 1-2)**.**

The next section, "Emerging themes and major issues," lists seven themes that have emerged to date from Commission discussions and the public testimony. The report is clear that these themes are not recommendations but were to be explored further in the course of the year.

Data Excerpt 5.3.

Defining Themes

> Facilitated discussion helped to define the following major areas for continued discussion based on perceived needs in the current system. (These are emerging themes for future deliberation and not recommendations at this time) (FCMHSA, 2000, March 1, p. 1-2)**.**

The last three sections address the vision of the Commission formulated during the November meeting (which will continue to be refined), future meeting dates, and a recommendations section, which state there are no recommendations at the time.

Extensive appendices (A-T) provide accountings of the activities, from the initiating legislation (Appendix A), to the Commissioners and their contact information (B-D), agenda of the meetings, business notes, and content notes (E-L, R), themes and venues for remaining meetings (M), advisory committee members and their letters of invitation (N-O), Public letter of invitation (P), monthly task timeline (O), public testimony at a non-Commission public meeting (S), and background reading material (T). One can consider the extensive appendices as accountings for past accomplishments as well as measures for future accounting of activities, e.g., the interim report references the creation of "work groups on specific projects. (See related documents in Appendices N and O)" (FCMHSA, 2000, p. 1).

The accountings are not just for the Commission as a discrete communication community; rather, it is also accounting for all of the communication communities (individuals and institutions) represented at the table *at any point in time*. The temporal component is essential since the public testimony was entextualized in the business and content notes and in videotapes available on the Commission website.

The Interim Report displays professional knowledge since it creates a consensual voice from the discourses of the Commission, invited experts, and the external stakeholders, as well as fulfilling its anticipated role as accounting to the Governor, the President of the Senate, and the Speaker of the House of Representatives. Hence, we see in the Interim Report the results of a situated accomplishment, centering on an account of everyday activities that are entextualized more widely into a discourse the addressees of the report will expect and understand. Further, this entextualization illustrates that

discourse produced for specific purposes, in turn creates the interrelationship between text and talk (Gunnarsson, 1997, p. 139).

The Interim Report is not the only account of the talk that occurred in its formulation, however. There is the transcript of the "State of the Science" meeting, and the accompanying business notes and content notes. A professional account should do two things. First, it should create a consensual categorization of activity and responsibility. Second, it should provide a coherent interpretation of the voices involved, in this case the voices of David, the Commission Chair, and Nancy, its Executive Director. As we see in Data Excerpt 5.4, David begins an accounting of who created the draft interim report.

Data Excerpt 5.4.

Preparing vs. Finishing the Report

David: governor on the first of March. And, so in keeping with our "just in time" philosophy that we try to embrace any place that I work. We finished this in the middle of last week which is actually for me would be early and send it out to all of you. You can see, Nancy prepared the report. Nancy, would you like to go ahead and talk about it a little bit then and see if there are any suggestions or additions? Sort of talk about our logic in terms of what we did in what we did to prepare it, or would you like me to do that?

Nancy: Uh, you can go ahead and do that if you'd like to.

As Chair David Shern reminds the Commissioners of their accountability to the legislative mandate, i.e., the interim report is due to the Governor, he starts to account for the draft report the Commissioners are to review. There are two accounts of authorship, "we finished the report" but Executive Director Nancy Bell prepared it (lines 76-78);

however, there is another "we" taking responsibility for the preparation (Data Excerpt 5.4, lines 76, 81, Data Excerpt 5.5, lines 108-114).

How David accounts for the authorship of the draft interim report can be examined in his use of pronouns: *we, I,* and *you*. Studying pronoun use provides insight into discursive collaboration. Pantelides and Bartesaghi (2012, p. 25) examine how use of these pronouns not only "mark important shifts" in the creation of a manuscript but also detail asymmetries in the writing relationship. Pronouns can present as inclusive, disaffiliative, and accusative as speakers use them to successfully strengthen their claims or to claim an identity as author (Haspel & Tracy, 2007). Inclusive pronouns may indicate that both parties are actively and equally involved in issuing directives; however, inclusive pronouns often disguise authority. For example, when an individual uses the phrase "We decided" rather than "I decided," the implication is that a decision is a joint decision (Rollins, Smith, & Westbrook, 2008).

The account is also at stake if viewed as a professional reporting of the authoring activities by David and Nancy. In Data Excerpt 5.4, lines 76-78, David's use of *we* appears to be an inclusive pronoun, in that *we*, Nancy and David, finished the report and sent it. However, *we* is an exclusive pronoun, as David disaffiliates from Nancy , in lines 69-70, as he shifts pronouns from *we* to *you* (an implied *you* since he uses Nancy's name). He further differentiates between who "finished" the report and who "prepared" it. This is accusatory, in that he connotes Nancy started the report but was unable to complete it. After all, "Nancy prepared" but "we finished."

The excerpt also illustrates a shifting of accountability from Nancy's role in preparing the document to David's construct of what should be described, that is, to "talk

about our logic in terms of what we did in what we did to prepare it" (Data Excerpt 5.4, lines 80-81). Although his use of pronoun *we* in this section appears inclusive, it is exclusive. David effectively excludes Nancy as an equal to him and as an equal role as "expert." He is driving the conversation to "our logic" and "what we did," which implicitly emphasizes that he played the major role in the "we." This is shown by Nancy's reluctance to discuss what "we did to prepare it" and after a brief pause, allows David to provide his accounting of their work. Her reluctance follows after David's use of an accusatory *you*. He appears to want her to elucidate, however, his disaffiliation from Nancy and the use of an exclusive *we* leaves her little choice but to allow him to explain. If she chooses to speak, she challenges his position as "expert." However, by not speaking, she has lost her credibility as "expert" and co-author. Much later in the meeting, she speaks at David's behest, but her expertise is limited to clerical and logistical reporting.

In Excerpt 5.5, David gives the logic (structure) of the report, drawing upon the discussions of the Commission to date. Not only does he report that the themes identified in the interim report were culled from the facilitated discussion in January, he acknowledges the topics identified as critical themes include themes that *would have* emerged as the Commission moves forward with their deliberations during the coming year (Excerpt 5.5, lines 87-88). However, he reiterates, the draft report is structured around the themes the Commission identified as most critical.

When David asks for reactions, the ensuing discussion indicates there is some doubt in the Commissioners' minds that the draft report accurately reflects the Commission. In Excerpt 5.6, several of the Commissioners perceive the bulleted list not

as a list of emerging themes but as a possible list of recommendations from the Commission (lines 102-104, 107, 115-116).

Data Excerpt 5.5.

The Logic of the Report

David: Well, essentially, as as you see from taking a look at the report, it really starts to talk about the the logic that we've used to uh conduct um, uh our meetings. How we've gone about organizing each of the days around topical areas. It summarizes the major topical areas of our discussion. It also summarizes what what would have emerged, I think, as the important issues that the commission is going to deal with and tries to draw out some of those issues in terms of a series bulleted statements, which are becoming I think is some of the structure of our deliberations and consideration. Importantly, the interim report also contains an extensive – our goal was to try to include with the interim report all of the material that has been collected by the commission to this point and

Excerpt 5.6.

Writing the Themes

Bob: I happen to be in agreement with them, but the way that the uh themes and major issues are read it almost sounds like recommendations.

Female: Mhmm.

Bob: Maybe nobody else has a problem with that?

David: You think it's a little too conclusory at this point and time?

Bob: It seems like that the way they're written.

David: I'll tell you what we did. Nancy went through and initially wrote universal assessment, improved access, integrated care and high quality, which pretty much, the bullets came directly from what we said last time when we worked with Eric Eisenberg. Um, then, Lonnie suggested and I think quite appropriately so, well, "What does that mean?" So, I took it upon myself to write what each one of those things uh meant or implied uh and that's why obviously we wanted you all to take a look at them and react to them.

Note also in line 105, Bob attempts to elicit additional support from the larger group for his belief by posing his statement as an interrogative. David attempts to clarify to the Commission how and who wrote what. David defends the list, attributing the list building to Nancy who took the themes from the facilitated discussion (lines 120-122); however, he does take responsibility for the definitions of themes (lines 124-125). Here the use of *we* is inclusive: Nancy, David, Eric, and Lonnie contributed to that section of the interim report and *we*, i.e., Nancy and I, want the Commission's thoughts.

Data Excerpt 5.7.

Including the Themes from the Public Testimony

142 Patsy: Um, we might just want to make certain that when we talk about
143 the emerging themes and the major issues that you know most of
144 the public testimony that we heard, I think that there are some very
145 definite themes…
146 David: Uh huh.
147 Patsy: And we just want to make sure that those major themes that we are
148 hearing in public testimony to date are included in all this, and
149 more than likely it is, but we just might want to keep
150 [indistinguishable]. because really this was like in an ideal world

It is at this point that Patsy, one of the Commissioners, raises the issue of the consumer voice, which appears to be missing from the draft. She wants the interim report to emphasize that the themes in the draft report clearly were taken from the public testimony (lines 143-144, 147-148). Here Patsy uses *we* as a way to show the thinking of the larger group (the Commission), building support and showing convergence of opinion.

The discussion continues. Another Commissioner concurs with Patsy (lines 141-144), and requests the text reflect, "that it wasn't just our thinking" (line 160) that "A lot

of what we came up with came from the public" (line 165), that this report "makes it sound like it's our thing; it's not" (line 155).

Excerpt 5.8.

Transcript "State of the Science" February 27 Meeting

156 David: Other thoughts or comments?
157 Man: Uh, two. One, uh at the top of the same section as commissioners shared
158 their individual perspectives my sense of that list was that it was not only
159 our own thoughts but it was also the integration of public testimony.
160 So, if we could add a phrase that reflects that it wasn't just our thinking.
161 David: That it's the thinking of the commission as well as its reflection on the
162 testimony that it had heard to that point.
163 Man: Yeah.
164 David: Yeah.
165 Man: A lot of what we came up with came from the public.

Here we see David offer a possibility to keep the original language. He suggests that the themes be described as the thinking of the Commission and a reflection on the testimony to date (lines 161-162). This provides the best of both worlds. The "public" provided testimony; the Commission heard and reflected upon what it had heard. This reflection is shown, to David's satisfaction, by the original language in the draft. However, this argument is not convincing to the rest of the Commission members. The Commission requested there be an explicit statement that there are no recommendations at this time (lines 181-184, 187-189, 195-196). The amended draft interim report would emphasize there were no recommendations and the focus is on the needs of Florida citizens.

In addition to the videotape of the business meeting, two other texts were generated: the business meeting minutes and the content notes. The February 27 business meeting minutes document many of the Commissioners' concerns. However, Patsy's

requests that the themes be identified clearly as coming from the public testimony were not reported. In Data Excerpt 5.9 from the minutes of the business meeting, the only request from Patsy is to have someone assigned to make sure the content notes accurately report themes.

Data Excerpt 5.9.

Business Meeting Minutes 2/27/00

> The Commission's Interim Report, due March 1, 2000, was then discussed. (Commissioners had received draft copies the week before for their review). Bob Sharpe commented that the stated "emerging themes" sounded like they might be recommendations. David McCampbell agreed. It was agreed that wording would be clarified. Patsy Holmes asked that past content notes be checked to be sure all themes were covered. Michael Spellman asked that it be made clear that public testimony had been integrated into the Commission's deliberations. Bob Sharpe suggested that the report state clearly that because of its early stages of deliberations, the Commission has no recommendations at this time.
>
> David Shern asked that the report be amended as above and submitted without further review by Commissioners, and Commissioners agreed

Examination of the public testimony section of the content notes from the February 27 meeting finds that the content notes are accountings of life with mental illnesses or substance abuse disorders. Some of the accountings have explicitly stated actions; others, however, do not. The content notes do not offer a summary of themes of actions, just selected snippets of the testimony.

In Data Excerpt 5.10, the interim report (FCMHSA, 2000, p. 2) reported these themes were derived from the facilitated discussions of the Commission, as well as the individual perspectives of the Commissioners based upon what they heard in public testimony. It is implied, not explicitly stated, that the themes were pulled from public testimony.

Data Excerpt 5.10.

Emergent Themes and Major Issues

> As Commissioners shared their individual perspectives on the current public mental health and substance abuse system and heard public testimony, dominant themes and major issues began to emerge. Facilitated discussion helped to define the following major areas for continued discussion based on perceived needs in the current system. (These are emerging themes for future deliberation and not recommendations at this time).

Hall, Sarangi, and Slembrouck (1999, p. 543) suggest "linking the everyday voices to the voices of wider concern" in accounting for an event or decision. I suggest such an accounting is rooted in previous occasions of text and talk. We see in the excerpts how the talk of the Commission was entextualized and recontextualized from the available data. I suggest the texts of the Commission are professional accounts of their work, i.e., the representation of the talk and the texts show the procedures used in situated sites, in this case, the Commission's "State of the Science" meeting. We see David accounting for who wrote the report, for how the themes were developed, and in whose voice(s) the report was framed. We see his reorienting to specific statements and questions he deems relevant as he accounts for the work he and Nancy did on the interim report. Further, we can see how the Commission's talk was recontextualized as the staff interpreted and documented what they heard.

The Final Report: Incorporating Multiple Voices and Texts

I now turn to examine the agency in statutes and legislation as recommended by the Commission and the recontextualization of voices as texts are created and used to substantiate and inform the *Final Report*. My data are the Work Group reports and the final report of the Commission.

The Workgroup Reports

In addition to public participation, the Commission was allowed to assign "committees as needed, composed of representatives of the commission and the advisory committee and employees of the involved state agencies" (HB 2003, lines 8-13, p. 10). This included appointees from the Florida Senate and House, the Secretaries of Children and Family Services and of Health, the Director of Health Care Administration, county government, and provider agencies. More importantly, the text specifically included a consumer of publicly funded mental health or substance abuse services, a family member of a consumer, and a representative from the Florida Mental Health Institute. By ensuring participation of these communication communities, the legislation mirrored the Surgeon Generals' request to have consumers and family members directly involved in public policymaking (US DHHS, 1999, p. 14). As members of advisory committees, these individuals would provide added content and context for the Commission in its sensemaking of stakeholders' needs in its final report due 1 December 2000.

In the February 27, 2000 "State of the Science" Meeting, the Commission created and charged four workgroups to provide additional information on the needs of three at-risk populations (children, adults, and the elderly with diagnoses of mental illnesses and/or substance abuse disorders) and a state-of-the-state assessment report on available state data. The Commission also made an accounting of its intent in appendices N and O of its interim report.

Genres are socially recognized types of communicative actions habitually enacted by members of a community to realize specific purposes (Orlikowski & Yates, 1994;

Gunnarsson, 1997). There are characteristics of a communication genre, such as use of lists and headings, fonts and formats, and specialized vocabularies.

A report genre serves as an institutionalized template. By using the template, two things are accomplished. First, a communication community shapes the actions of its members through their use of it. Second, the genre is reinforced as a distinctive and useful organizing structure for the community. When a genre is not adopted by all the members of a communication community, texts may have little in common with each other or even with iterations of the same text. Changes in structure may make it difficult to synthesize data or recommendations across texts or across iterations. Barley (1988, p. 51) reminds us, "slippage between institutional templates and the actualities of daily life" may result in inadvertent or unintended changes as individuals and groups negotiate and interpret their charges.

Hence, a number of factors, such as speakers' codeswitching, changes in vocabulary, hedging, or genre in texts intended for different audiences, create problems when arguing public policy issues for different audiences and contexts. Although code-switching is traditionally thought as switching between one or more languages in the context of a single conversation (Blom & Gumperz, 1972), codeswitching also is a practice of parties in discourse to signal changes in context by using alternate grammatical systems or codes as a means of structuring talk in interaction (Auer, 1984). Hence, code-switching does not simply reflect social situations; it is a means to (re)create social situations, such as minimizing differences between one person and another or one group and another.

In the politics of representation (Mehan, 1996), institutional representations generally prevail, as "[e]ach mode of representation relationally defines the person making the representation and constitutes the group of people, and each does so in a distinct way' (Mehan, 1996, p. 254). Individuals and institutions construct public policy using institutional and social language 'shorthand.' Such shorthand influences stakeholders across political, economic, and societal dimensions. Codeswitching can be tracked as changes in vocabulary occur, such as the adoption of another participant's professional language or, when a speaker relates his or her idea with the social values of a larger group.

Using terms from another professional discipline may be seen as an attempt to bridge a perceived breach or ensure alignment to the speaker. Referencing social values associated with an idea shows a significant investment of time to buy into a specific idea (Tracy, 1997, p. 39). Further, certain conversational moves are identifiable as interactional strategies, either at an individual identity level or as a group-level dilemma. These moves include individual reflection (e.g., "it seems to me", "I mean"), outright agreement ("saying", "think", "wondering"), recognition of shared constructs ("as it's been said"), or the use of a larger "other" ("we", you plural) (Tracy, 1996, p. 16).

Hedges, such as "I think" or "it seems to me," serve several functions. As a discursive strategy, a hedge is used to distance oneself from a prevailing viewpoint or to note uncertainty. In other instances, a hedge may mark the utterance as a formulation of the speaker's own thoughts. The phrase "I mean" may indicate that the speaker is expanding or clarifying his or her conceptions of an idea or it can indicate intent, particularly if the listeners miss a previous statement. It may also function as a remedial

event, clarifying a misinterpreted intention, thereby reestablishing the mood of the interaction (Schiffrin, 1987).

How does one craft a singular case yet be recognized as part of the same argument? This is the question under consideration as we examine the four workgroup reports. The workgroups were to explore an identified issue and report their results and recommendations back to the Commission. Their findings and recommendations would be used to inform the final report of the Commission.

Majchrzak (1984, p. 99) suggests a policy report should be structured in a specific manner to ensure its receipt by the policymaker. First, the beginning of each section should summarize major points. Second, headings for each section should be explicitly descriptive, i.e., "encapsulate information." Finally, an executive summary of less than five pages should precede the body of the report.

A close examination shows that *Mental health: A report of the Surgeon General* follows this structure. Since *Mental health* was a critical text for the Commission and the nation, paralleling its structure would strengthen a communication genre for "reporting" mental health for the state. To do so, each of the workgroup reports would contain a literature review that defines its recommendations and continues *Mental health*'s primary messages: mental disorders are health conditions and mental health treatments are effective. However, none of the reports followed this format. Although the reports provided some sort of introduction, either by the way of a formal introduction or through the use of an executive summary, each report had a different structure from the others as shown in Table 5.1.

When a workgroup makes recommendations, their understanding of a policy and its outcomes cannot be separated from the entextualization and reconceptualization of the issues at hand. These processes are embedded in our communication communities and genres. The authors of the four reports represent a diversity of institutional and experiential constructs. HB 2003 clearly requests, "A final report with recommendations, including any modifications of current law" (HB 2003, 1999, lines 24-25, page 10).

Table 5.1.

Structure of Workgroup reports

Data 11 pp.	Children's 25 pp.	Adult 28 pp.	Older Adult 43 pp.
"prepared by" Introduction	-- Executive summary (3 pp.)	"prepared by" Introduction	"prepared by" Executive summary (7 pp.)
Findings	Methods	Scope of the problem	Mission
Need for services	Findings	The MH and SA Service System Recommendations	Case for needed services
Services being provided	Vision for the system	System failures Recommendations	MH SA needs
		System-wide issues Recommendations	Specific elder MH SA issues
			Findings
Recommendations (4)	Recommendations (14)	Recommendations (45)	Recommendations (13)
	Conclusion		
References embedded as source name in text	References	References	References
		Appendix Minority report	

For a policy report to be credible requires the use of experts and evidence. Credibility can be shown by clearly linking findings to concerns explicitly identified in the enabling document, e.g., HB 2003. Of the four workgroups, only the Data Workgroup report clearly ties its research objectives to HB 2003. It will "review the current information management system for MHSA services and assess its capacity to

monitor MHSA services delivery" (Kip, 2000, p. 1). This simply stated objective ties directly into the systematic review of the state mental health system, which is working with technology and data collection models more than sixteen years old.

In an examination of the services currently provided by the state, the Data Workgroup was unable to provide estimates of persons being served because there was insufficient data to estimate unmet need, utilization of services, or prevalence of disorders across child, adult, and older adult populations or among particularly vulnerable populations, such as persons with mental illnesses and/or substance use disorders who are homeless. These gaps in data and data analysis pointed out by Kip (2000, p. 5) are shown in Data Excerpt 5.11.

Data Excerpt 5.11

Data Workgroup Report on Services Being Provided

> Insufficient data exist to estimate the total percent of unmet need for MH services among children and adolescents. …
>
> Insufficient data exist to estimate the annual prevalence of substance abuse/dependence (based on DSM criteria) in children and adolescents 0-17. …
>
> Insufficient data exist to estimate the total percent of unmet need for MH services among adults across [word missing in the original]. …
>
> Insufficient data exist to estimate the total percent of unmet need for SA services among adults. …
>
> Therefore the percent of treatment need met by DCF contract providers and other providers cannot be estimated at present.

The Data Workgroup couched its recommendation for a statewide data integration system to work with existing systems and to use state-of-the-art statistical

modeling applications to provide more accuracy and better information from existing data streams.

Recommendations for the Final Report

HB 2003 clearly requests "A final report with recommendations, including any modifications of current law" (HB 2003, 1999, lines 24-25, page 10). To meet this mandate, the workgroups ideally would link recommendations to statute or FAC, much as legislative staff analyses are structured. However, this was not the case.

Of the 14 recommendations made by the Children's Workgroup (Cohen & Haines, 2000), resources were requested specifically to support pilot demonstration programs described in Chapters 394 and 397. Many of their other recommendations are broadly painted, such as creating an integrated services system, increased funding and support for Medicaid part H services, and parent involvement in local and state level planning and policy development.

The Adult Workgroup report (Boaz & Crockett, 2000) recommended broad changes to the Baker and Marchman Acts (Chapters 394 and 397) regarding evaluation and treatment, and that patients' rights language be inserted into the Acts, using language in Chapter 400 FS (nursing homes) as a model. It also recommended Chapter 394 part IV be rewritten to accommodate the 45 recommendations presented in the chapter. However, it gave no specific guidance as to the sections impacted by the 45 recommendations or to other statutes that would be affected. The Adult Workgroup also recommended creation of a Behavioral Health Authority "to take statewide responsibility for the planning and accountability of the entire MHSA services system" (Boaz & Crockett, 2000, p. 24).

The Older Adult Workgroup made recommendations that would require changes to the FS, however, the specific statute(s) and sections never were identified. Their recommendations regarding pre-service and in-service education and training geared toward aging populations urges collaboration among "providers, licensure boards, professional organizations, and educators" (Parks et al., 2000, p. 29). These recommendations might affect the authority of the Florida Certification Board regarding professionals working across numerous mental health and substance abuse sectors and the creation of specialist programs and/or concentrations in higher education programs.

Unlike the other three workgroups, none of the recommendations made by the Data Workgroup explicitly or implicitly required changes to existing statutory or regulatory authority as embodied in the FS, the Laws or the FAC.

Communication communities account for their work in many ways. One of those ways is through communication genres. Genres provide established, identifiable structures and lends context for their work (Yates & Orlikowski, 1992; Orlikowski & Yates, 1994; Gunnarsson, 1997). Ideally, in the construction of the four Work Group reports, we would see how each group depicted the complexity of the issue they studied. Further, we would see the integration of the Workgroup findings as mutually constitutive sets of texts across many communication communities and genres. Although the Workgroups provide accountings of their work through their reports, i.e., a "state-of-the-state" review for the Commission, and while they contextualize the issue(s) and offer evidence to substantiate the weight of their claims and recommendations for improvement, there is little evidence that the reports were conceptualized as a mutually constitutive set of texts to be written to support a larger text (i.e., the Final Report).

Although the process of mutual knowledge construction across many texts addressed to different audiences is not unique in policymaking, it appears that this knowledge was not requested by the Commission or was it acted upon by members of the workgroups. Rather, it appears as if each report was constructed as a stand-alone document by individuals within the workgroup creating the text for review by the workgroup (Data and Adult) or by all participants in the workgroup (Children and Older Adult). Only the Data workgroup report was incorporated as a reference and as an implied recommendation for improved services and utilization statistics in the other three population-focused reports.

I suggest that the workgroups failed to become a communication community as seen through the lack of a coherent communication genre, i.e., the structure of their reports and use of language, and the failure to "read" as mutually constituted texts. Further, I suggest the structure of the reports and the language of the recommendations made it more difficult for the Commission to meet the mandate given by HB 2003.

Preparing the Final Report

People produce, reproduce, and change genres through a process of structuring (Yates and Orlikowski, 1992). Writing a series of evaluative policy reports is more than knowing how to write a report for a specific audience. To write a report that is one of a series requires an individual to understand how to structure the report so that it easily is identifiable as a stand-alone report but also as one report of a series. This knowledge is more critical when the report will be used to substantiate a larger review of the complex issue of which your report is but one part. Consider that the four workgroups sent 76 recommendations to the Commission for consideration in the preparation in its Final Report.

Wording of issues, in particular, may be changed radically, affecting content and context. However, in a text that announces itself as building on another, it is reasonable to expect support of overarching arguments, claims, and conclusions. The core of the argument should remain constant across genres, audiences, and accountings. The foundational texts for the final report included *Mental health: A report of the Surgeon General*, the business meetings of the Commission, the public testimony, the business meeting minutes, the content notes, the interim report, and the four workgroup reports.

The Role of the Academic Contribution in Texts

Locke and Golden-Biddle (1997) suggest texts themselves provide opportunities for contribution and signify the importance of a specific contribution through a number of rhetorical strategies. Generally public policy documents do not contain extensive bibliographies. The Surgeon General's intensive use of the academic literature to substantiate its claims in the construct of mental illnesses and substance abuse disorders illustrates the change within public policymaking to incorporate scientific evidence in texts.

Academic disciplines form distinguishable discourse communities, which have their own social patterns of writing (Gunnarsson, 1997). The function of the scientific article is central to these communities. Within the workgroup reports and the final report, we see the emphasis on expert and evidence. Three of the population-focused workgroup reports used academic and research references to substantiate their claims. The Data workgroup used primary data sources (i.e., state service utilization data) to create reports to substantiate the gaps in the current information management system, providing evidence as to what information it could not determine. The three population-focused

reports included references to studies conducted by the research faculty and staff of Florida Mental Health Institute (FMHI). In addition, the Older Adult report extensively referenced previous policy and technical reports prepared by members of FMHI's Department of Aging and Mental Health.

Genres of academic writing contextualize and reflect how knowledge is created. It is through minutes and content notes, draft reports, working papers, technical reports, and other generic forms of writing that communication and discourse communities come to a shared understanding of a policy issue. Berkenkotter and Huckin (1993, p. 476) suggest genres "package information in ways that conform to [community] norms, values, and ideology." Gunnarsson (1997) and Ravotas and Berkenkotter (1998) argue that the mixing of different voices in texts are related to different sources and to different audiences. Linnell (1998, p. 153) adds that

> recontextualizations have not only a retrospective side, being selective transformations of prior discourse, but also a prospective aspect, addressing particular audiences and thereby partly anticipating *their* (re)interpretations (and recontextualizations).

The scientific or empirical model also emphasizes evidence and expert knowledge. Sarangi (1998) describes how the evidentiary status of a report changes across texts. A "fact" may not be a "fact" unless there is direct evidence. Further, he suggests what may be *clearly* evidence for one community may be seen as *only* circumstantial evidence for another. Hence, recontextualization of issues is a strategic move that is used to prefer and to disprefer one set of claims over another.

Of the 76 recommendations that went forth to the Commission, nine were recommended to the Governor. Statutory changes would be required to accomplish two major objectives. The first objective would be to establish a statewide mental health and substance abuse office similar to that of the Office of Drug Control Policy. The second objective would be to redefine and clarify the role of traditional mental health and substance abuse programs to better target resources, increase service utilization for persons most in need of care, and provide greater flexibility in contracting and purchasing services. To explain how the Commission reached their conclusions, the final report was structured with a letter to Governor Bush, Senate President McKay, and House Speaker Feeney, an executive summary, a history and overview (Chapter 1), findings (Chapter 2), and recommendations (Chapter 3). These were followed by a copy of HB 2003 (enabling legislation), a dissenting opinion, and references. Accompanying the Final Report was another text, the compilation of the four workgroup reports.

Although the Commission was comprised of a diverse group of stakeholders, in Chapter 1 of the Final Report (overview), David Shern, the Chair of the Commission, describes the Commission as "made up of diverse professionals from throughout Florida" (Florida Commission, 2001, [i]). Further, there is no formal mention of the role consumers and family members played in the development of these recommendations, "the body of this report is a synthesis of the extensive work done by the workgroups and the full Commission" (Florida Commission, 2001, [p.iii]). The reader may postulate that, during the year-long meetings and research, there was the inclusion of other voices to inform the Commission; however, it is not until Chapter 2 of the Final Report (findings) that the other voices are invoked. The letter ends with a request for the recipients to read

the attached workgroup reports as they contain "specific findings and recommendations" (Florida Commission, 2001, [p. iii]). The four workgroup reports also provide more accountings and claims as to the seriousness of the issues faced by persons receiving mental health and substance abuse services, in effect invoking additional expert knowledge and evidence.

Similar to an academic paper, Chapter 1 of the Final Report establishes the issue under review, a method, and the results of that method. A survey was sent to selected respondents in each of the ten state agencies providing MHSA services. Using results of the survey, the report describes the system structure and planning, services, and financing and contracting of each of the ten state agencies. Chapter 1 clearly reflects the institutional voice of those agencies, as written by academics.

In Chapter 2 of the Final Report, the voices of the consumers and family members are heard along with the voices of professionals. This chapter incorporates a second genre to its structure -- qualitative research, in that it incorporates quotations by and descriptions of persons involved in the MHSA system. Eighteen excerpts are set aside from the body of the text. Of those 18 set-asides, nine are direct quotes from professionals, five are direct quotes by consumers, and five are stories about consumer experiences in the third person. Although the professional and the lay communities appear to be represented fairly equally, I argue there is a significant difference in their portrayal as expert. In the discussions on the constructs of expert and evidence across these chapters, there is the tacit assumption that both professional knowledge and lived experience contribute to expert and evidentiary status. However, in Chapter 2, all nine of

the professional quotes are in 14-point Times Roman with 12 points of white space above and below the quote (see Figure 5.1).

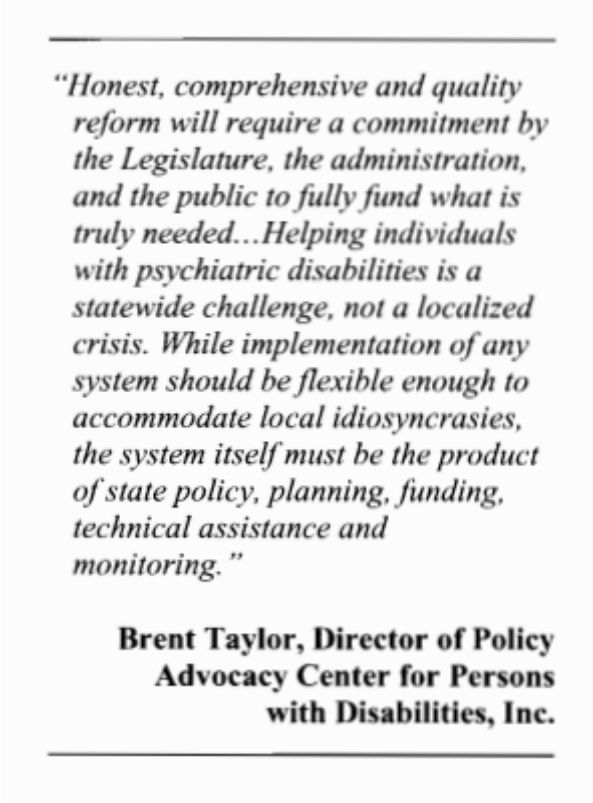


Figure 5.1. "Professional" Quote Format

The quotes are enclosed with a one-point rule above and below the quote. Each quote is attributed to an individual using his or her full name, professional title, and institution. Each quote is in the first-person. Although one of the professional quotes is from the director of an advocacy center, it is included in the professional category since the organization is a state-incorporated non-profit agency and the quote deals with system reform.

Of the ten consumer quotes or stories, only two quotes, attributed only to "Consumer," use the same set-aside format used by the professional quotes, i.e., 12 point

Times Roman 12 point white space, and open rule boxes. These quotes address stigma and trans-institutionalization, respectively.

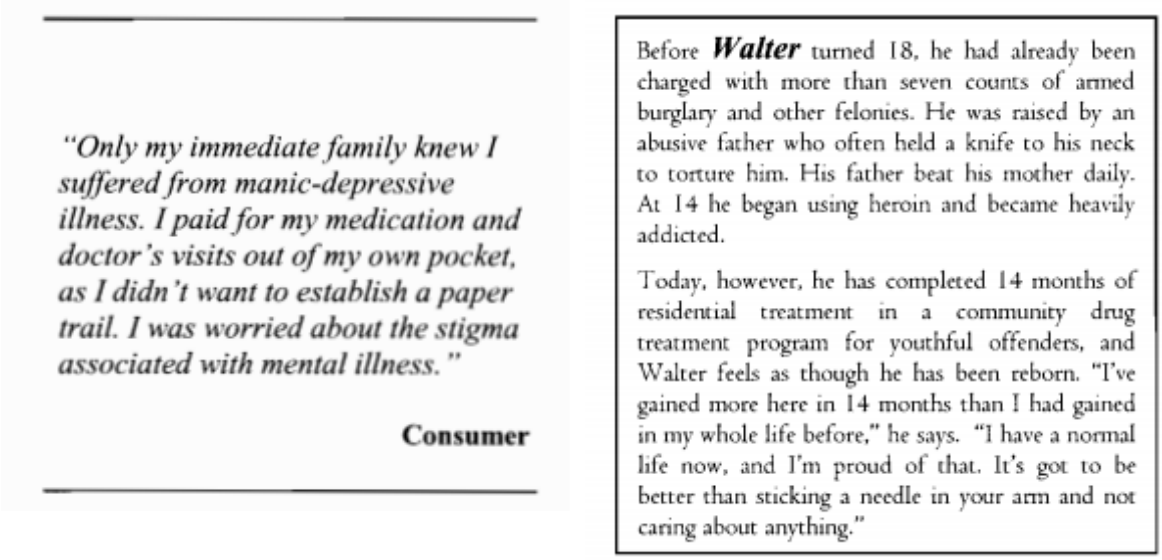


Figure 5.2. "Consumer" Quote Format

The remaining eight stories are in 9 point Times Roman enclosed in a one-point box. The eight consumers have only a first name. Three of the "named" consumer stories are told entirely in the first-person; five are in the third-person. Of the five third-person accounts, three include a quote about the individual in the story.

The eight consumer stories follow the traditional story genre when writing about persons with mental illnesses and substance use disorders. All of the stories talk of the consumers' downward spirals and, where they are today. Rod, Noreen, Daryl provide first-person accounts. Each story begins with the now familiar acknowledgement of a person who has no power over a disease, "My name is Rod, Noreen, Daryl and I have <insert disorder>." The stories of Walter, James, Sarah, Kirk, and Juan are told in the third person. Of these five stories, only Walter's story has a positive ending. Included at the end of his story is a quote, where he states, "I have a normal life now, and I'm proud

of that" (p. 23). James has never been assessed formally by the juvenile justice system; he now lives in a supervised group home. Sarah "aged out" of foster care and is homeless. Kirk, who had paranoid schizophrenia, was killed by police during a Baker Act procedure. His story begins with a third-person summary; Kirks' father explains what happened, ending as saying, "[Kirk] was frightened and he just wanted to be left alone" (p. 31). Juan's story is summarized by Judge Cohen, 11th Judicial Court Dade County. She says, "He could be helped before it's too late. But I have nowhere to send him (p. 36).

It is left to the reader to move beyond the pathos of their stories to find the relevant service provider that assisted them, i.e., the caring caseworker, the halfway house, or the 12-step program. This is not meant to diminish impact of their stories or their accomplishments in recovering from their disorders. However, I suggest that in a report to change the system, consumer suggestions should be in the forefront: a better trained workforce, supported services in a community-based setting, transitional services, increasing access to mental health and addiction services across all services sectors, and better screening and assessment. I also suggest the report would have been better served by giving equal weight to both the professional and consumer viewpoints, both in formatting and by addressing higher-level policy concerns.

In Chapter 3, the Commission offers its recommendations. HB 2003 explicitly asked for a list of any statutory changes that may occur as a result of the recommendations. Recommendation number 3 requests changes to the Baker Act (§394.4625, 394.463, and 394.467) and substance abuse services (Part IV Chapter 394 FS and 397), specifically the system of care principles reflected in 397.97 FS be applied to

adult substance abuse services. However, the full statutory impact (much less logistics) of establishing a Coordinating Council for Mental Health and Substance Abuse Policy comprised of eleven state agency representatives, six consumers and family members, two representatives of county government, the Florida Chamber of Commerce, and other interest groups represented in the Commission is disregarded.

Certain genres are established over time as being successful in conducting and accounting for a community's activities. Members of a community enact a genre by drawing on their knowledge, tacit or explicit, of a set of genre rules. By using a selected genre, such as a policy report, a community hopes to reinforce and substantiate its claims to effect successful policymaking. I suggest the academic genre fails in the writing of a report meant to galvanize change and as a report to the Governor, Senate President, and Speaker of the House. The final report, even combined with the four workgroup reports, failed to provide a coherent vision for transforming mental health and substance abuse services in the state. Since spoken discourse and written texts are forms of both professional and institutional interaction (Tuffin and Howard 2001), context is "dynamic, reciprocally emergent … between professional and institutional practice and accounting in various forms" (Bartesaghi 2009, p. 159). In public policymaking, how the group accounts for itself in institutionalized talk, such as meeting minutes, content notes, facilitated discussions, public testimony, the interim, workgroup, and final reports, may be transformed radically as one way of accounting is preferred over another way. A discursive approach allows us to see this recontextualization.

Summary and Conclusion

Kaufer and Carley (1993, 1994) suggest there is a historicity in the "literate practices and print as sociocultural constructions" by groups. Public policy groups, i.e., the Florida Commissions on Mental Health and Substance Abuse are comprised of members of numerous communication communities who become members of the group known as the Commission as well as numerous external stakeholder groups. Members share their institutional norms and attitudes with each other and create their own norms and attitudes for this artificially created group, which includes knowledge about and practices of performing text and talk.

The Florida House of Representatives authored HB 2003. That text charged the Commission to perform a number of tasks, including a formal accounting of its activities in interim and final reports, respectively detailing its progress and making policy recommendations. The Governor sanctioned this text, giving it weight and authority to act. The interim and final reports entextualized and recontextualized the systematic review of Florida's mental health and substance abuse services delivery system. These reports spawned new legislative texts and are found in accountings of reports of legislative staff analyses and in other state and policy documents. These written texts were created for specific purposes bound by the contexts of members of numerous communication communities.

As Austin (1962) reminds us, we "do things with words." Words in legislation implement service provision, afford protections, or regulate societal and individual behavior. Words in formal deliverables are accountings. Words from public and invited speakers contextualize an issue for the audience. Words among Commissioners result in

acknowledgements of the complexity of an issue, identification of key themes, and in formal recommendations. All of these words are entextualized and recontextualized over time and space. In the case of the Commission, its *Final Report* not only directed human actions but also recommended actions designed to revise the current agency of texts and to generate new agency for future texts. However, as we have seen, the Commission was simultaneously constrained and mandated by legislative texts directly and indirectly. For persons interested in public policy review, a discursive approach tracking the interrelated texts and the agency of these texts illustrates the difficulty of resolving an identified public policy issue.

CHAPTER SIX: MAKING SENSE OF THE BLACK BOX

> Discourses frame certain problems; that is to say, they distinguish some aspects of a situation rather than others (Hajer, 1993, p. 45).

The public expectation is that policymakers will study the problem and find an expeditious solution. Here, as Hajer (1993) reminds us, lays the paradox of the policy process itself: the words and ideas used by the world of policy simultaneously describe and define both policy problems and solutions.

Over the past twenty years, I have been privileged to work in a mental health research institute where the framing and investigation of public policy problems is de rigueur. I am reminded daily of the inherent difficulties in cross-walking among the disciplines, praxis, and theory that make up the social construction of mental health services delivery, mental health research, and mental health policy. As the answers I needed grew more complex, so did my questions. I became intrigued by the discourse of public policy and how best to disentangle it, starting with the products (talk and texts) and the processes of public policymaking. I began to see public policy as the endpoint of a discursive process of negotiations of claims, stakes, identities, and competing visions. Using a discursive approach, I could show how mental health policy is the situated accomplishment of talk in interaction. This dissertation is the end product of my attempts to make visible that which is invisible, that is, what goes on in the black box of policymaking. To do so, I chose to examine the workings of the Florida Commission on Mental Health and Substance Abuse.

The Florida Commission on Mental Health and Substance Abuse was "talked into being," as Heritage (1984) would say, by a group of individuals concerned about the state of Florida's public sector mental health system. Moving across the Florida House of Representatives and the Florida Senate, House Bill 2003 gave birth to a Commission that would first conduct a systematic evaluation of the "state-of-the-state" in the provision of services to persons with mental illnesses and substance abuse disorders and then provide recommendations to improve services. The twenty-three Commissioners represented a variety of statewide stakeholders, including mental health and substance abuse providers, hospitals, employers, insurance carriers, family members, and consumers of public services. With the addition of the Chair of the Commission and an external facilitator, the Commission met every month for over a year, in different locales across the state. Their charge was to create a vision to guide the transformation of services in Florida. However, I believe the real charge of the Commission was to bring about change: change not only in the services delivery system but also a change in how policymaking was conducted in Florida.

My Reflections on the Public Policymaking Process

Historically, government decision making is a process of advocacy and bargaining guided by the power and interests of stakeholders or a political platform. The policymaking process originates at a specific location of a policy institution. That institution may be a legislature, a state agency, or an advocacy group. The policymaker makes a clear statement of intent, often with a list of specific steps and expectations for implementation at every level. Whether the policymaker is a single individual (Elmore, 1979) or a group of stakeholders who, speaking as one, identify the policy problem,

possible strategies, and the solution (Sabatier, 1986), both types of policymakers work within organizational boundaries and sectors to create a network specifically created to solve the identified problem. Whether the process is top-down or bottom-up, the focus typically is on understanding the implementation structure, developing typologies and indicators for program performance, and interviewing stakeholders from all levels for their input and reactions.

This input is driven by the stakeholders' perspective regarding the importance of the topic. Perspectives tend to be pragmatically or theoretically oriented (Rochefort, 1994). The pragmatic significance often addresses "real life" terms, such as allocation of resources or the larger social well-being of an identified group or community. The theoretical significance focuses more on the anticipated insights of an area for the public policy-making process in general. More often than not, however, the problem will be reframed into manageable "bits." After all, Banfield (1980, p. 18) suggests, the public perception is that public policy problems are "too complicated for ordinary people to deal with."

It is how these "bits" are framed, named, and made sense of that concern us most in the policymaking process. Otherwise, we are lost in the institutional void, that black box, of policymaking. How is a problem identified? What criteria are used? What arguments are put forth to substantiate the claim that "X" is indeed a problem? Who decides what is evidence? Who is the expert? Whose voice(s) are heard? Who acts? Who or what is the agent for change? These are the questions that arose in my study of the talk and text of the Florida Commission on Mental Health and Substance Abuse.

In normal or routine policy changes, there is no significant shift in the balance of power or redistribution of resources. Routine policy change is the tacit reinforcement of an existing understanding of a socially constructed issue, event, or action. The institutional discourse may not change significantly and any change will be consistent with present understandings. Second-order policy change, however, involves the development of new policy instruments and strategic action. Second-order policy change has the potential to solve an identified social problem, altering power and resources, revising fundamental rules and processes of social systems (Giddens, 1984; Fischer & Forester, 1993). Second-order policy change also requires a change in shared understanding. For second-order change to occur, individuals must become suspicious of certain directional changes and examine them carefully to determine whether core concepts and actions still make sense. This is not an easy thing to do when taking a macro-level view of value systems, legislation, regulatory requirements, organizational structure, cultural practices, or resource availability.

Consider the complexity of the de facto mental health system. It is huge, comprised of both public sector and private sector services. Each sector operates independently of the other, with its own agencies, funding streams, services, and operations. The system provides acute and long-term care in home, community, and institutional settings, across the specialty mental health sector, the general medical/primary care sector, and the voluntary care sector. Professional licensing and accreditation organizations, managed care provider entities, advocacy and regulatory agencies, and health care policy making groups influence how local, state, and federal governments deliver and finance care. In addition, state and federal laws, administrative

policies, funding priorities, advocates' concerns, and organizational culture and climate create additional structures that are involved in change efforts. How a person enters the system and one's trajectory into care greatly influences the discourse that surrounds the provision of and problems in mental health services delivery.

Historically, in the United States, second-order policy change is endemic in the labyrinthine public mental health service systems. Exposés of asylum conditions in the 1940s and early 1950s led to a number of federal studies on the state mental health hospitals. In 1955, Congress passed the Mental Health Study Act, leading to the establishment of the Joint Commission on Mental Illness and Mental Health. The Joint Commission's 1961 report became the basis of the Community Mental Health Centers Act of 1963. The Community Mental Health Centers Act resulted in the beginnings of the community-based care movement. However, with no investment in community treatment facilities, and the closing of residential facilities, deinstitutionalization went from being a solution to an identified policy problem as persons with mental illnesses and substance abuse problems had no treatment centers and no place to live. The Stewart B. McKinney Homeless Assistance Act of 1987 was enacted to provide for shelter programs and supportive services for persons with mental illnesses and substance abuse problems, who were homeless. Numerous other Acts and legislation have been passed to improve public sector mental health services. Regardless of the day, month, year, or decade, mental health services delivery can be defined not only as a persistent policy problem but as a perennial "hot potato."

The public mental health system, however, is not just a delivery system. It is comprised of numerous systems of institutional, professional, and lay discourses. Each

of these discourses has a particular perspective on how to formulate and identify the issues under study or the population affected by a policy change. Discourses are framed around and by a person, a group, an institution, a policy, or a government. Each name or representation, "relationally defines the person making the representation and constitutes the group of people" in a distinctive way (Mehan, 1996, p. 254). As institutional and social languages become shorthand, this shorthand influences stakeholders across political and societal dimensions. Hence, change in public mental health systems is by definition complex and has far-reaching consequences.

Why should we care? Perhaps the better question is, "How can we not care?" Fourteen percent of the global burden of disease is attributable to mental disorders (Prince et al., 2007); four of the top ten causes of disability in the world are mental illnesses (Murray & Lopez, 1993). Consider that Federal and state governments create numerous commissions, task forces, and legislative committees to address how mental health services should function and for what purpose. Commission, task forces, and committees create hundreds of thousands of documents. In addition, hundreds of thousands of hours of the talk in commissions, task forces, and legislative committees have been notated, transcribed, and/or videotaped. Hundreds, if not thousands of voices can be heard in and through the talk and texts of public policy. We need a way to make sense of the voices heard in this policy talk and texts.

However, the study of policy discourse is not simply an epistemological or methodological exercise in describing the attributes or effects of a policy. It is also ontological, in that talk both defines policy and is itself defined by policy. Talk and text have agency yet simultaneously are constrained in a matrix of other texts and talk. How

do we see this? By showing the constitutive and co-constructed elements of talk and text. This became the focus of my first analytic chapter.

Process and Product: Seeing the Communicative Chain

Policy talk is not merely rhetoric; "policies are textual interventions into practice" (Ball, 1993, p. 12). It is through the written and spoken discourses that we can see the processes of organizational communication with a public policymaking group. There are process- and activity-oriented perspectives within an organization. A process-oriented perspective represents the organization as "sets of defined tasks and operations such as those described in methods and procedures, which fulfill a set of business functions" (Sachs, 1995, p. 36). The activity-oriented perspective suggests that the actions necessary "to accomplish business functions is complex and continually mediated by workers and managers alike" (Sachs, 1995, p. 37). By combining the two perspectives – process and activity – we can examine how work gets done (Sachs, 1995).

Hence, to see the patterns of communication and their relationships among a public policy group and its stakeholders, we first need to determine the "communicative chain" of process and activity as seen in the written and spoken discourse of an organization (Gunnarsson, 1997, p. 169). A communicative chain shows how text and talk (i.e., written and spoken discourse) interact in the communicative process that occurs in everyday activities. This is not an easy task. The written and spoken discourses that make up a specific communicative event may be so intermingled that it may be difficult to determine the borderline between them. Further, the more complexity involved in an activity, the "longer and more complex the communicative chains" (Gunnarsson, 1997, p. 183).

At the beginning of the Commission's communicative chain, I started with the enabling legislation. Legislation and legislative language play a key role in establishing, empowering, and constraining public mental health agencies. We see this in House Bill 2003, with the need for the state *or its agent* to review and update the Florida Statutes in regard to the provision of mental health services, possibly redefining the authority of mental health agencies across federal, state, and local levels of operation. After the inception of the Commission, we see the structural role of law, as entextualized in HB 2003, in shaping the agent who will act for the state. Further, we see the agents acting for the Governor of the state interpret HB 2003 as they outline the organization, powers, prerogatives, and duties of the Commission in its first orientation meeting. Hence, the law and its agents shape the ability of the Commission to function and ultimately its impact on public mental health services system.

We also see the generation of talk and text that surrounds the Commission, informs the Commission, and is created by the Commission. We see how comments made in the business meetings are entextualized or recontextualized as tasks or in the interim report, i.e., the Commission's accountings of its work. We also see the break in the chain of talk when requests made in the business meetings are not rendered into text as tasks. The close reads of the text and talk afforded by a discursive approach have shown us much of how the organizational processes of organization occur as part of the "doing" of work.

By tracking the communicative chain of the Commission, I was able to discern the formation of the "extended we", the emerging collective identity of the group as it attempted to create a shared understanding of the complexities of the public sector mental

health system in Florida. To become experts about the issues, the Commission needed to call upon numerous experts across the many communities that make up the infrastructure and the recipients of mental health services. We see the first invocations of expert and evidence in its communicative chain.

Determining Expert and Evidence

To understand expert and evidence, we must first understand how these are framed in the context of mental health research, particularly services research. Mental health services research is an integrative, interdisciplinary field, utilizing basic and applied research to examine a number of domains. Domains include utilization, accountability, delivery, organization, financing, costs, quality, and outcomes of services. The causal model for research in each domain takes into account the context in which the public mental health sector functions. To do so, the model examines its resources, processes, and services; and outcomes. The inclusion of expert knowledge and evidence in health services research ties new knowledge (research) to current knowledge (practice) in an analytical process, thereby incorporating a systemic perspective of research and practice.

When the Office of the U.S. Surgeon General officially framed mental health as a national public health issue in 1999, it did so with the best evidence of the previous decades, "Research has given us effective treatments and service delivery strategies for many mental disorders" (U. S. Department of Health and Human Services, 1999, p. [iv].). We see how the Office of the U.S. Surgeon General built an effective argument; it laid out the science base and described levels of evidence. In determining who was "expert," it expanded the traditional definition to include both scientific research of the empirical

community, the clinical research of the practitioner community, and the "lived" experience of the consumer and family member communities.

In the *Report*, there is a careful crafting of each expert as the reader moves thorough the chapters. In addition, the reader is given an equally careful construction of the evidence that supports the findings of the experts: the efficacy of treatment is well documented and people should seek treatment for mental illnesses as they do for somatic illnesses. The reader also sees the *Report* identify the biggest obstacle to reforming mental health: stigma.

In the public policy process, many individuals, ranging from expert witnesses to fellow stakeholders, provide information on many topics and in many forms. Further, policy systems privilege rational or expert knowledge. Traditional knowledge is "legitimate," often with little discussion of lay or non-expert experience. Expert knowledge, such as the close relationship of governments with established think tanks, for example, is acceptable. Expert knowledge relies upon facts; however, not all facts are equal. An expert selects certain facts to convey a point of view, to buttress an argument, to favor one decision over another. Ideally, expert information broadens access to policy makers the useful knowledge available within the research community. Such information may be inaccessible to or unrecognizable by policymakers until it is crafted into "simple arguments that challenge practices and ideas," (Nelson, 1989, p. 408), such as the U.S. Surgeon General's report on mental health.

Policy actions are dependent on expert and evidentiary policy knowledge; interpretations by policymakers reflect and sustain specific ideologies and beliefs. If we can see how an object -- the text itself -- is ascribed the status of expert and evidentiary,

we can see how certain languages (professional, lay, and expert) and certain practices (evidentiary or experiential) are preferred and dispreferred by both human and non-human objects (Cooren, 2006) active in the policymaking process. A discursive approach provides the tools with which to disentangle the threads of the arguments made by the scientific and lay communities and to see a whole cloth in constructed to give each its community due consideration as expert and the value of its evidence.

This is critical information as policy process models often neglect the relationship between experts and stakeholders in the policy knowledge process. Experts are stakeholders as well as stakeholders may be experts. However, there is little systematic investigation into the "why, when, and how" expert knowledge is utilized by decision makers, particularly *which* expert knowledge stakeholders use and/or create. This expert knowledge is in the reports and the legislation that are the final products of the public policy problem-solving activity. By carefully examining these documents, I believe there are glimpses in problem clarification and an exploration of the alternatives presented during the policymaking process.

Agency, Texts, and Voice: The Making of a Final Report

Within a public policy process, participants of various stakeholder groups have different notions of the goals of the process; in turn, these are closely related to their notions of success. Therefore, in any collaborative setting, one encounters negotiating roles (identity), creating social order (relationships to one another and the community), developing knowledge (what each view as true), and eliciting values (setting social policy). How individuals situate themselves is found, not only through possible conflicts, but also through intersubjectivity, i.e., the process of establishing one's identity and sense

of self and the claims made through discourse. Individuals speak for self, for another, or for a larger "other." To do so, various discursive strategies are used to make claims to the "extended we."

To speak for others requires an analysis of claims and accountings often resulting in a formalized report. In policymaking, there are internal and external indicators to assess the quality of the analysis. Internal criteria question process and fact, such as how a policy group handled uncertainty or their consideration of the strength of the evidence (Majone, 1980). External criteria are those criteria imposed from the outside, including client/public limitations as well as time- and resource limitations. These criteria also affect how and what information is presented to the decision-maker (Majone, 1980).

In today's world of public policy, facts may be seen as social constructions, not only as objective statistical measures. Science itself is seen as a product of the social world, "grounded in and shaped by normative suppositions and social meanings" (Fischer, 1993, p. 167). This is evident when one examines the inevitable need for "change" in the public sector. However, for such change to occur, we must focus on the written and spoken discourses that frame policy questions, contextual argumentation, and normative presuppositions so that we understand "political" reality as socially constructed.

By understanding discursive strategies, such as institutional and social language "shorthand" or consistency in viewpoint, we see how the reports of the Commission – interim, workgroup, and final – are written for a specific audience, within specific institutional structures, and how each was influenced and adapted to a specific set of norms, attitudes, and values. Consistency in viewpoint, for example, is critical in coming

to consensus, for visions, for process, and for products. Through the use of discourse markers or discourse genres, members create consistency in their talk, differentiating intended messages, better positioning their causes, and serving as a barometer when interests realign. Discourse markers provide coherence, showing relationships between the different units of talk (e.g., ideas, actions, and turns). They also provide meaning and functions as individuals co-construct definitions or choice of actions. Discourse markers may indicate segments of talk or text as description, as explanation, or as narrative. Discourse genres provide talk via professional or advocacy shorthand as well as referential frames to further agreement.

Discourse strategically shows how the talk generated by the Commission and the testimony by public stakeholders were reframed into a specific discourse that would result in the generation of texts and textual agency. Like so many other policy reports, the Commission's final report recommended a number of actions from its immediate readers, the Legislature, as well as future actions by other stakeholders and future texts. Hence, it is critical that texts are not studied in isolation but through the relationship(s) a text has through context and reader evaluation.

Future Question for Exploration

One question that remains with me as I complete my study of the Commission is whether a discursive approach can clarify the relationship between statutory language and the performance of public policy commissions when examined from the perspective of outcomes in the public mental health system.

The Value of a Discursive Approach

I argue that it is through the written and spoken discourses of its stakeholders that policy is enacted into institutional language. Hajer (1995) defines a policy discourse as a "specific ensemble of ideas, concepts, and categorizations that are produced, reproduced, and transformed in a particular set of practices and through which meaning is given to physical and social realities" (p. 44). To study talk (or text) in context (Tracy, 2001) requires a discursive approach.

Consider the Commission and its documents. Videotapes of policy meetings show talk in interaction. Institutional documents show not only how that talk is embedded in text but also how talk is transformed to meet institutional needs. A discursive approach examines the evidence presented to substantiate a point of view, illuminating the arguments created to prefer or disprefer ways of seeing the world. Such an approach allows us to see the naming and framing of a problem, boundaries established during its formation, and the creation of shared meanings that move policymakers to action. Discourses, created for and by specific audiences, privilege certain types of evidence; a particular discourse persuades its intended audience(s) of the reasonableness of a course of action.

I suggest that the overall importance of institutional health discourse lies in its multiple meanings and the scope for contesting meaning aroused by these many layers and perceptions. Further, multiple stakeholders use a variety of discursive strategies to minimize personal, organizational, and political risk as they engage in making sense of the identified problem and possible solutions.

A discursive analysis allows me to follow the communicative chain of text and talk, tying together method and sensemaking in the policymaking process. By analyzing the many discursive connections -- formal, rhetorical, and logical -- that comprise the policy making process, I show how these connections work together to produce meaning. Such an analysis can be expanded to not only implicate philosophical or political debates, domains of knowledge, and practices, but to understand better the discursive strategies members of a policy group use in real-life public policy settings.

The situatedness of person, place, and historicity provides the context used in the co-construction of meaning, the framing of talk, the making or forwarding of a claim: i.e., how texts transform prior texts and restructure existing genres and discourses to generate new texts. This is particularly critical with the reconfiguration of public policy as discursive space. I suggest that such a reconfiguration better enables investigations into analysis of policy *as it is created*.

Implications and Recommendations

There is a distinction between "policy as text" and "policy as discourse." Policy as text is a representation of policy formulation, such as tweaking the delivery of public sector services. Policy as discourse exercises agency through knowledge as a "truth" spoken to a "power" (Wildavsky, 1979). Knowledge and this "truth" are constructed through experts and evidence. Expert and evidence are brought together as "practical processes of argumentation" (Fischer and Forester, 1993, p. 1). These practical processes are found in the talk and texts of policy.

Policy "changes the possibilities we have for thinking "otherwise" (Ball, 1993, p. 12). In this chapter, I offered not only a summary and my reflections on what I have

learned but on the value of a discursive approach to the study of public policymaking and policy analysis. As a process policy analysis and policymaking wends its way through a number of stages: public recognition of a problem, adoption of laws, incorporation into administrative codes, and finally program implementation, with evaluation and assessment. However, through close readings of available text and talk we can have a better understanding of the discursive construction of the public policymaking process.

We are able to see the constitutive and constructive nature of discourse in the text and talk of the stakeholders seated at the table, as well as those who are striving to be seated at that table. We can see the claims and accountings put forth as individuals and groups try to make sense of the "right" issues in the "right" way, so that everyone's voices are heard. We can also see how these voices are entextualized and recontextualized to begin the discourse anew or reframed to substantiate a yet-unheard claim or voice. We can examine how expert and evidence are constructed. We can see how the agency of texts simultaneously is constrained by, and constrains actions in the public policymaking process.

When I think about the impacts of public policies, my thoughts used to run to the innovations in health sciences and services research, the issues involved in moving research to practice, the still-fragmented de facto system of mental health services delivery, and the difficulty coordinating interstate and intersectoral policies and regulations. As I write this closing chapter, I find renewed enthusiasm to support an alternative construct for mental health services, research, and policy.

There are continued emphases to review and evaluate the success of changes in public sector health services research (Bhandari, Scutchfield, Charnigo, Riddell, & Mays,

2010; Institute of Medicine, 2011; U.S. Department of Health and Human Services, 2000, 2011). Some researchers, such as Bhandari et al. (2010), suggest structural capacities of a public health system affect the mission and performance of the system. These capacities include human, physical, and financial resources; organization and relationships; and agency information and technology (Bhandari et al., 2010). The Institute of Medicine (2011) acknowledges an increased emphasis on accountability in the public and private sectors. It recommends using better research methods to assess the strength of evidence regarding the health impacts of public policies.

On the flip side of policy research, there are questions being asked as to the role of the policy researcher. Colebatch and Radin (2006, p. 225), for example, want answers to "how policy workers get a place at the table." They also ask, "What sort of activity do practitioners see as policy work, and what sort of policy workers do they recognize" (Colebatch and Radin, 2006 p. 225).

Whether the question is on services research or the role of the policy researcher, the value of a communication approach is significant. A communication perspective offers us opportunities to explicate a particular practice's interactional problems. With an understanding of the problems, we can note the conversational moves that reveal them, and determine strategies to manage them. Not only does a communication approach identify ideas and dilemmas, it offers a process on how to choose what to accomplish and how to accomplish it. Finally, not only can the links between a policy or change paradigm be determined, it is possible to connect these links together to create a chain of previous, current, and future discourses.

I asked, “Who speaks?” “Who speaks for whom?” “Who or what has agency?” “What are the constitutive and co-constructed elements of this discourse?” There are no easy answers to any of these questions. However, it is these questions that are asked repeatedly in numerous texts on policy analysis, in examinations of methods for policy research, and in philosophical and practical texts on framing public policy. Policy analysis requires many tools; discourse analysis provides more than general claims about paradigms or discursive strategies. It provides an established analytic perspective to open the black box of public policymaking to gain a broader understanding of how policy is socially constructed.

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APPENDICES

Appendix A: Commissioners & Facilitator

Commissioners	Location	Title
Allen, Terry H.	Palm Beach	CEO of 45th Street Mental Health Center
Clary, Senator Charlie	Destin	State Senate
Cohen, Jeri B	Miami	11th Judicial Circuit judge
Haines, John	Tallahassee	Regional Vice President, Children's Home Society of Florida
Holmes, Patricia	Tallahassee	Vice President Operations, Henry & Rilla White Foundation, Inc.
Kang, Rodney, M.D	Maitland	physician
Lestage, Daniel B., M.D.	Jacksonville	Vice President Professional Relations and Quality Compliance, Blue Cross/Blue Shield
McCampbell, David S.	Pembroke Pines	Human Resources Manager, BellSouth
McKinnon, Mary J.	Orlando	Administrator, Orlando Regional Healthcare Systems
Morris, Charles W	Shalimar	Okaloosa County Sheriff
Murman, Sandra, Representative	Tampa	House of Representatives, Florida Legislature
Parks, Sallie	Palm Harbor	Pinellas County Commissioner
Pomm, Raymond, M.D.	Jacksonville	Psychiatrist
Schuck, Laura M.	Bradenton	CEO Carter Behavioral Health Systems
Sharpe, Bob	Tallahassee	Assistant Deputy Director for Medicaid, Agency for Healthcare Administration
Shern, David L., Ph.D.	Tampa	University of South Florida (Chair)
Singleton, Jeremiah	West Palm Beach	Regional Vice President Hanley-Hazelden
Slate, Risdon N., Ph.D	Lakeland	Criminology professor, Florida Southern College
Sloyer, Phyllis	Tallahassee	Director, Division of Network & Related Programs, Department of Health
Spellman, Michael, Ph.D.	Ft. Myers	Psychologist, Center for Psychology and Neuropsychiatry
Steele, Dianne M.	Indian Shores	Veterinarian , family member
Williams, Bob	Tallahassee	Director of Programs, Department of Children and Families
Williams, Irvin J.	Pensacola	Addictions professional Lakeview Center
Eisenberg, Eric *Facilitator*	Tampa	University of South Florida, Professor, Department of Communication

Meeting/Speaker/Affiliation

Meeting/Speaker/Affiliation	Discourse Community
DECEMBER 1999	
1. John Petrila, Chair, Dept of Mental Health and Policy, FMHI	Academic/*REPORT*
2. Martha Lenderman, Consultant, Lenderman & Associates	Professional
3. Bob Dillinger, Office of the Public Defender, 6th Judicial District	Agency-state-Law/ Crim Justice
4. Terry Taggart, Tampa Bay Depressive & Manic Depressive Association	Consumer
5. Stan Skipper	Family member
6. Gayla Sumner, Department of Juvenile Justice	DOC-JJ /agency
7. George Hinchliffe, Department of Juvenile Justice	DOC-JJ/agency
8. Pam Denmark, Dept Corrections Substance Abuse Programs	DOC-SA/agency
9. Judge Don Evans, Drug Court, Hillsborough County	Law/SA
JANUARY 2000	Academic/
10. Robert Friedman, Ph.D.. Chair, Dept Child & Family Studies, FMHI	*REPORT*
11. Sue Ross, Acting Chief, Children's Mental Health, DCF	Agency/DCF/MH
12. Ken DeCerchio, Asst. Secretary, Substance Abuse, DCF	Agency/DCF/SA
13. Robert Nolan, Ph.D., Exec Dir, Children's Psychiatric Ctr, Dade County	Provider/MH
14. Shelley Gottsagen	Family member
15. Randi Solomon	Family member
16. Michael Shuler	Family member
17. Judge Kathleen Kearney, Secretary DCF	Agency/DCF/Law
18. Fotena Zirps, Ph.D., DCF	Agency/DCF/academic
19. John Bryant, Asst Secretary, Mental Health Program Office DCF	Agency/DCF/
FEBRUARY 2000	Agency/NIH/
20. Dr. Howard Goldman, Director of NIH	Academic/*REPORT*
21. Alberto de la Torre, M.D., Medical Director, Renaissance Behavioral Healthcare Systems, Jacksonville	Medicine/Provider
22. Dick Warfel, Executive Director, River Region Human Services, Jacksonville	Provider/MH/SA
23. Ruth O'Keefe, JD, MBA, CPA, Professor, Accounting, Jacksonville University	Academic/Professional Family Member
24. John Rutherford, Director, Dept of Corrections, Jacksonville Sheriff's Office	DOC-Sheriff/Agency
25. Angela Vickers, Attorney, FL HB 675, Student Education in Mental Illness	Law/Advocate
26. Fred Spears	Consumer
27. Sandra Adams, PhD, Infant Mental Health Project Co-director	Academic
28. Nancy Fudge, Jacksonville	Consumer
29. Carol Caldwell, Attorney, Mental Health Advocacy Project Community-based Care Jacksonville Area Legal Aid, Inc.	Law/Advocate
	Professional

APRIL 2000	
30. Martha Lenderman, Consultant, Lenderman & Associates	
31. Cindy Meftah, Chief, Adult Mental Health DCF, Baker Act Issues	Agency/DCF/MH
32. Jim Berko, Executive Director, Seminole Community Mental Health Center, Fern Park, FL	Provider/CMH
33. Dev Chacko, MD, Chairman, Dept of Psychiatry, Florida Hospital South, Orlando	Medical/Provider-Hosp
34. John Lamos, MD, Chair of the Emergency Department at Florida Hospital	Medical/Provider-Hosp
35. James Herndon, Staff psychologist, Orange County's Sheriff's Department, Baker Act training	Medical/DOC-Sheriff
36. Alice Petree, Member of Mental Health/Baker Act Task Force	Family member/State-MH Task Force
37. Bob Constantine, Executive Director, Florida Council for Community Mental Health	Association /FCCMH
MAY 2000	
38. Dr. Alan Leshner, Director, National Institute of Drug Abuse	Agency-Fed/SA
39. James McDonough, Director, Florida Office of Drug Control Policy	Agency-State/SA
40. Ken DeCerchio, Director, Substance Abuse Program Office, DCF	Agency-State/SA
41. John Daigle, Executive Director, Florida Alcohol and Drug Abuse Association	Association/SA
JUNE 2000	
42. Dr. Gema Hernandez, Secretary, Florida Department of Elder Affairs	Agency-State
43. Dr. Richard Powers, Director, Bureau of Geriatric Psychiatry, Alabama Department of Mental Health & Mental Retardation	Agency-State
44. Carol Egan, CAP, ICADC, Director, Older Adult Services, Hanley-Hazelden	Provider-Private
45. Cindy Meftah, Chief, Adult Mental Health, DCF	Agency-State/DCF/MH
46. Dr. Larry Polivka, Director & Associate Professor Florida Policy Exchange on Aging	Agency-State
47. State Mental Health Planning Council (SMHPC)	Agency-State
JULY 2000	
48. Dr. Martin Cohen, President & CEO, MetroWest Community Healthcare Foundation, Framingham, MA	Provider-Private
49. John Bryant, Assistant Secretary, Mental Health Program Office, Department of Children and Families	Agency-DCF/MH
50. David Rogers / Shelly Brantley Medicaid, Agency for Health Care Administration (AHCA)	Agency-AHCA
51. Jim Nathan, CEO Lee Memorial Health System, Fort Myers	Provider-Private
AUGUST 2000	
52. Carol Bracey, Legislative Director, Florida Association of Counties	
53. Dr. Paul Rollings, ADM Program Supervisor, District I	Association/Policy
54. Lucia Maxwell, Managed Care Consultant; Executive Director, Panhandle Area Health Network	Provider-Private
55. Gary Bembry, Chief Financial Officer, Lakeview Center	Provider

56. Ron Manasa, Executive Director, Manasa Consulting Group representing NAMI	Advocate
57. Beverly Seiple	Consumer
SEPTEMBER 2000	
58. Randy Borum, Psy.D., Dept of Mental Health Law and Policy, FMHI	Academic-Law
59. Greg Teague, Ph.D., Dept of Mental Health Law and Policy, FMHI	Academic
60. Terry Allen, CEO, 45th Street Mental Health Center	Provider-Private
OCTOBER 2000	
61. Hendricks Brown, Ph.D., Professor, USF College of Public Health	Academic
62. Pam Waters, Assistant Director, Florida Alcohol and Drug Abuse Association	Association/SA
63. Jo Heller, NAMI	Advocate
64. Angela Vickers, Attorney, District 4	Lawyer/advocate/consumer

Appendix B: Transcript State of the Science Meeting

David: We've distributed the minutes of the meeting to you both in hard copy format and also electronically. We are aware that we have been having some bumps in terms of our electronic distribution system. We'll uh actually Nancy will be discussing this with you in a little bit. Um, but you should have had adequate opportunities to receive both the content minutes from the meeting as well as the very nice summary I think that Nancy prepares for us of the testimony that is delivered by each of the persons appearing before the commission. The chair would entertain a motion to approve those minutes. Second?

Group: Second.

David: Are there any questions or additions to the minutes? Patsy?

Patsy: Yes, I do have a couple of corrections under the report on the personnel committee.

Nancy: Alright.

Patsy: And I made this mistake because I indicated that the committee recommended that the commission contract with the Florida Mental Health Institute, and I think that really should say that the department should contract with the Florida Mental Health Institute. And in the second statement, well I guess it was up at the very top when I thanked Ken for his assistance, and I think I also said a note of special appreciation to Lonnie Mann who's also with DCNS. So if you could include him also, please?

Nancy: I'll make those changes.

Patsy: Thank you.

David: Any other questions or additions to the minutes? Well, I'm going to take the liberty of amending your motion to approve the minutes as amended which is what I should have done. I should have called for amendments or corrections before, and I can't recall who seconded it, but my guess is that it is a friendly amendment so the second one will also stand. All those for approving the minutes as amended say, "Aye."

Group: Aye.

David: Oppose, "Nay." [Pause.] The motion carries. Approval of today's agenda as you can see, we are going to go through a brief business meeting. And actually, as you can't see, but I think as all of you are aware, that will be followed by a hour presentation approximately by Dr. Howard Goldman. And, again, I'll tell you a little more about Dr. Goldman in a few minutes. And then we have an opportunity for open discussion and questions about really about the implications of the report for the Florida

Mental Health System. And, as I talk about Howard, you'll see he's not only is he distinguished by being the senior scientific editor for the report but he really has a very rich and varied background in terms of public mental health systems and persons with chronic mental illness. He's an extraordinary resource. So, after we talk about the report, we'll perhaps have an opportunity to chat with Howard about some of his other perspectives and feelings about the public mental health system and the role the evolving role of systems to protect the public's mental health. So, that'll be the agenda for this evening. Tomorrow, we're going to focus on testimony around implications for the Florida Mental Health System relative to the Surgeon General's report, have open testimony. A new addition to the agenda is that we're going to propose tomorrow to you the assembly of I think what will be our first of what will probably be several work groups. We will have a brief presentation by an epidemiologist from FMHI who has been working on need and resource estimates for the state that I think you will find interesting. And, what we want to do is panel a group to start working on these needs and resource estimates. And, finally, we'll end tomorrow rather than starting with the facilitative discussion with Eisenberg. He's going to come in at the end of the day. There was some sense that by having Eisenberg first we were sort of playing short-shrifts to the testimonies since the commissioners, many of them, have to leave in order to get late afternoon flights. So, we wanted to move the facilitative discussion to the end. We also thought it would be nice for us to have had an opportunity to have a lot substance and to be thinking about that when we enter into the discussion rather than prior to actually having heard testimony, or in this case, really thinking about the Surgeon General's report. That's generally the logic. We're going to try to adjourn by three tomorrow afternoon, so we can get everyone out in time for tomorrow afternoon's thunderstorm. So, are there any comments or additions to the agendas other than those ones that I've sort of suggested? [Pause.] Now, Nancy has distributed to you all both again electronically and in terms of more conventional methods, a copy, of our interim report. You'll recall that, although it's hard to believe, the first report of the commission is due to the legislature and the governor – Nancy, or just the legislature? – both to the legislature and the governor on the first of March. And, so in keeping with our "just in time" philosophy that we try to embrace any place that I work. We finished this in the middle of last week which is actually for me would be early and sent it out to all of you. You can see, Nancy prepared the report. Nancy, would you like to go ahead and talk about it a little bit then and

see if there are any suggestions or additions? Sort of talk about our logic in terms of what we did in what we did to prepare it, or would you like me to do that?

Nancy: Uh, you can go ahead and do that if you'd like to.

David: Well, essentially, as as you see from taking a look at the report, it really starts to talk about the the logic that we've used to uh conduct um, uh our meetings. How we've gone about organizing each of the days around topical areas. It summarizes the major topical areas of our discussion. It also summarizes what what would have emerged, I think, as the important issues that the commission is going to deal with and tries to draw out some of those issues in terms of a series bulleted statements, which are becoming I think is some of the structure of our deliberations and consideration. Importantly, the interim report also contains an extensive – our goal was to try to include with the interim report all of the material that has been collected by the commission to this point and time including the content notes, any correspondence we've received, et cetera, et cetera. So, uh, I'm very interested, as I'm sure Nancy is as well, to uh hear your reactions to the report, any suggestions you might have, um, and what we'll do is make whatever modifications you feel are important and submit it on Tuesday. Are there any reactions?

Bob: I have one.

David: Bob. Yeah?

Bob: I happen to be in agreement with them, but the way that the uh themes and major issues are read it almost sounds like recommendations.

Female: Mhmm.

Bob: Maybe nobody else has a problem with that?

David: You think it's a little too conclusionary at this point and time?

Bob: It seems like that the way they're written.

David: Uh huh. Other reactions to that? I'm going to drive Alex crazy because I'm going to up here and see Nancy.

Bob: David.

David: Yeah.

Nancy: Is that what you're looking for? There's a copy.

David: Yeah. I don't know where my packet went. Do you have an extra copy?

Nancy: There's only one copy, but you can use it.

David: Bob, do you have a suggestion to how we might change those so they sound less conclusory. For example, for the first one.

Bob: I don't know that we have to change them.

David: OK. You just want to make sure that people feel comfortable with them?

Bob: Yeah.

David: I'll tell you what we did. Nancy went through and initially wrote universal assessment, improved access, integrated care and high quality, which pretty much, the bullets came directly from what we said last time when we worked with Eric Eisenberg. Um, then, Lonnie suggested and I think quite appropriately so, well, "What does that mean?" So, I took it upon myself to write what each one of those things uh meant or implied uh and that's why obviously we wanted you all to take a look at them and react to them.

Man: I have uh I mean I think they do look as though kind of a conclusion has been made, but I don't think – I think it's general enough that it's not a problem. The only thing I suggest is if anything's missing there in those you're talking about the bulleted themes, right?

Bob: Yeah.

Man: If there's anything there that's not really included, you might want to actually speak now or forever…

David: In terms of the interim report but obviously this is really just – I mean the way I thought of this is as an update of our thinking at this point in time, this is the information we collected, here's some of the themes that are emerging.

Man: Uh, because this came from that little workshop we did, right?

David: Right. This came from the facilitated discussion where we identified those issues. [Pause.] Patsy.

Patsy: Um, we might just want to make certain that when we talk about the emerging themes and the major issues that you know most of the public testimony that we heard, I think that there are some very definite themes…

David: Uh huh.

Patsy: And we just want to make sure that those major themes that we are hearing in public testimony to date are included in all this, and more more than likely it is, but we just might want to keep [indistinguishable]. because really this was like in an ideal world

Male: Right.

Patsy: what would the mental health and substance abuse system look like.

David: Right.

Patsy: So, it might cover all the themes that we've heard, but it might be something to check.

David: Other thoughts or comments?

Man: Uh, two. One, uh at the top of the same section as commissioners shared their individual perspectives my sense of that list was that it was not only our own thoughts but it was also the integration of public testimony.

So, if we could add a phrase that reflects that it wasn't just our thinking.
David: That it's the thinking of the commission as well as its reflection on the testimony that it had heard to that point.
Man: Yeah.
David: Yeah.
Man: A lot of what we came up with came from the public.
David: Yeah.
Man: And also I assume that some readers will get down to the bulletins and stop on full focused funding and that's the one they'll read.
Uh, I wonder if it's really that we're looking for full focused funding on our goals or on the needs of the Floridians or something other than the commissioners – the commissions' goals. Even the commissions' recommendations might – it makes it sound like it's our thing; it's not.
David: So, you would suggest that maybe we add that we modify that to say "to ensure that uh Floridians receive adequate mental health and substance abuse services."
Man: More in that direction would be my thinking.
David: Okay, that's fine. I think that's a really appropriate comment.
Guy: I'd hate for us to lose focus because I think that was the issue…
David: Yeah.
Guy: …for many of us – that the funding needed to be adequate to meet needs, but it also needed to be specifically focused and a part of some kind of clearly understood, thought out, focused utilization of resources because it's – I think the other conclusions were that there were lots of resources that perhaps weren't focused now, consequently weren't generating benefits that made them as valuable as they might be…
David: Right.
Guy: if they were better focused.
David: Right, or we might not know a lot about the benefits of or problems with those services. So, I think that's a good point. And you're not, Michael, suggesting that we change focus at all?
Michael: No.
David: We've been joined by Risdon Slate. Risdon, welcome.
Risdon: Thank you. I spent the afternoon with truckers on I-95.
David: Did you, did you really? So, you're in like in a really good mood. Wait 'til I tell you about Howard's flight down and that will make you feel better.
Bob: I had one other thought.
David: Yeah, Bob.
Bob: The legislature when they get reports like this, they look for

recommendations, and this is an initial interim report. But, do you need to say that there are no explicit recommendations being made to the legislature in this report?

David: That would be – I would be fine with that. It certainly is not our intention at all. And you're obviously, there's something that you're obviously reacting to in the wording here that is causing you uh to feel a sense of caution about this so.

Bob: Well, not that. But it it just seems to me that if we're not making recommendations at this point that we ought to tell the legislature that it would be…it's too early…to do that.

David: Okay.

Patsy: Just make that statement.

Bob: Right, just make that statement.

David: Okay. Oh, it's much too early. And this is really intended to be kind of a framework to organize our discussion rather than any set of conclusory remarks.

Bob: Alternatively, there though the commission won't be making any legislative proposals this session.

David: Right. Yup.

Man: You know, you could place that in the under that paragraph with emerging themes and major issues because I I agree they're going to look to that – they're going to read them as recommendations I think. And if it starts off with you know there are no recommendations being made at this time, however, you know there are themes there et cetera.

Man: Inaudible.

Man: Yeah.

David: Other comments? [Pause.] Okay, now from a process perspective we'll make those modifications. Um, would people like us to submit it on March 1 as a draft and formally approve the changes or do you feel comfortable that the changes are minor enough that we can just go ahead and submit it as the report of the commission?

Group: Inaudible.

David: Yeah. As as as long as it reflects our discussion tonight which is I think would be fine.

Group: Inaudible.

David: Uh, can I have a motion to that effect?

Man: So moved.

David: So moved. Diane seconds the fact that we will submit this interim report to the legislature on time on March 1 with the suggested changes reflecting the fact that we're not doing any recommendations and that

our focus is not on the products of the commission but on the needs of Florida citizens. Okay? Excellent. Report of the Executive Director. Now would you like to give the Report of the Executive Director or would you like me to?

Nancy: I'll handle it.

David: Okay. Go ahead.

Nancy: Can you all hear me from here? Or, I guess I better come up there huh?

Man: You have a mic right there.

Nancy: Oh, does this work?

Man: Male Voice: We've been listening to your conversation through dinner.

Nancy: I'll just leave now then. Okay, um, just a few points I wanted to make. I think we're making good progress in organizing the business of the commission and um developing some systems that will work well for all of us as we go along. Within the next week or two we expect to hire a part-time program assistant who will help tremendously with transmitting, communicating, uh interfacing with the members of the advisory committee, many of the uh the sort of communications and basic issues that we need to have some help with. So, that should be happening I'm hoping this coming week. We also have uh started receiving resumes for two part-time research assistant positions. Those people will help tremendously when we get into the work groups, the projects, the reports, the position papers, the documents that we are soon going to soon start producing. So, soon we will have some more staff support and that will be very very welcome. We're archiving the media coverage that we've gotten. Uh, many of you I'm sure have taken a look at our website and may recognize that uh some of the most recent information is not yet on the website, but we expect that to happen very quickly, and we'll get that up and running and uh fully functional just as soon as possible. Um, as David mentioned earlier the epidemiologist from the Florida Mental Health Institute will be speaking briefly tomorrow about his research and needs assessments and his data in Florida. This is kind of a kick off of what we expect to be our first work group. And, uh, we can talk more about that tomorrow, but that's another way that we're looking at organizing the the data and the resources that we have particularly in working in conjunction with the Florida Mental Health Institute. As far as the advisory committee, we have about 25 members. As you may recall when we met last, we um had not gotten um a really large response from the initial invitees to be on the advisory committee. I sent two or three weeks ago a follow up letter asking those who had not responded to that initial invitation to please consider

participating. We have gotten a very good response to that, and we've got maybe six or seven more people calling saying that they would like to participate. So, we have a good list, and I think a good mix.

Uh, I have a copy with me of the list of the committee members if anyone would like to see them. They are also included in the appendices to the interim report. Um, these committee members will be invited to attend all commission meetings. They will be sent all the material.

They are being sent all the material: agendas, all the advanced material, all the minutes, um, really most of what you all are getting. And, then as we develop projects and work groups and committees, however we, um, you all decide to organize, the people who have expertise in particular areas who serve on the advisory committee may be asked to work with small groups, to testify, to make comments, speak at meetings, and just lend their expertise. So, we're looking forward to that. Thirdly, uh, as we have already mentioned a couple times this morning, we are aware that some of you have heard maybe a little more from us than you might have wished the last month or so and some of you I think have heard a little bit less. And, we recognize that that's a problem, and we put our heads together last week and decided to um, see exactly what method of transmission of materials works well for each of you individually.

So, in front of you right underneath the agendas is a questionnaire that was prepared uh by us last week to see if we could just get some specific information on how you find it easiest to get information from us.

And, if you would fill out that questionnaire and give it to one of us this evening, that should go a long way toward helping us know whether um whether we can e-mail you material, whether we need to fax it or what works best for you, so I do apologize to those of you who have been inundated with many versions of the same thing and for those of you who haven't been able to access some of the data. I think we are well on the way to getting that resolved. So, if you'll just give that completed questionnaire to any one of us sometime this evening or even tomorrow, that would be terrific. I think that's about it.

David: Okay, thank you. Are there any questions for Nancy? [Pause.] Nancy, uh, you in fact talked about the status of the contract with FMHI. I don't know. Lonnie. Where's Lonnie? Do you have anything to add on that?

Lonnie: It's in the process.

David: It's in the process?

Lonnie: Yeah.

David: Um, so we're going through uh essentially negotiating the contract. Now, we don't anticipate there will be any problem. Yeah.

Lonnie: [unintelligible] We found [unintelligible]
David: Okay. Good. That's always that's nice of you to tell us that now. Um, and, uh, Nancy's report on the advisory committee I think the invitations and the response to people gets us through that part of the agenda.
Nancy: Mhmm.
David: Okay. Um, is there any old…
Pam: [unintelligible]
David: I'm sorry, Pam.
Pam: I'm not sure. Is this on?
David: Yeah. It's on.
Pam: I guess it is. I just wanted to bring up again on the advisory committee the idea that I had brought up at the last meeting about having an advisory committee, another subgroup um consisting of clients with mental illnesses, so that anything we do we are sure that it is something that will benefit them from /// aspect, so we don't end up doing this finding out in the end that everything we did really wasn't going to benefit them. And, I just wanted to know if anything has been followed up on that or what anybody thinks.
David: We had, I'm trying to remember, we had agreed to table that last time in anticipation of uh filling out this the sort of the formal advisory committee that we had talked about. Had we then, I need some help remembering what we had decided. Had we decided that we would use sort of ad hoc rather than in paneling. My sense of the of the commission last time was that there wasn't a tremendous amount of support for paneling another advisory committee; in fact, doing that was almost seen as uh I'm going to say setting up a two-class system, but that's wrong. [unintelligible] Our goal in the advisory structure was to try to build as broad a constituency base as we could for the reports of the committee so that it would be it would reflect the views of a broad base of constituents. My sense was there was a lot of agreement that it is critically important that primary consumers be involved in every way possible in terms possible of commenting on the report. Um, and that we wanted to see how the advisory committee structure ultimately filled itself out prior to thinking about constituting a second kind of advisory committee.
Is there – is that even close to what we said?
Man: David, I think the thought was that on that list of potential advisory committee folks that there were some consumers.
David: Right.
Man: But I don't know that is true that there are or not.

David: Yeah, no, there are consumer and consumer groups represented.
Man: Well, not so much, I think what Diane is talking about aren't the advocates but the consumers themselves. And, I agree with that. I'd like to see at least some I don't know two, three, four, uh, well, probably three, four, or five actual clients. I mean, you know real life actual consumers not advocates for consumers on the uh you know – in the advisory. I think that would be very very helpful.
Man 1: David, can we ask uh NAMI uh perhaps to give us uh a list of some uh potential consumers and any other consumer groups that we have uh represented in terms of advisory committee. And then, w maybe we can go from there just taking a look at that as a possibility.
Nancy: NAMI is recognized or is uh included on the advisory committee.
Man 2: Yes.
Man 1: Yeah, NAMI is on the committee, but I I I'd like to make that distinction that we're not – I'm not interested – I mean I'm interested in people like NAMI, but I'm especially interested in what like Diane is talking about: actual, current consumers of mental health services, clients, um, as opposed to their advocates.
Nancy: Okay.
Man 1: I agree.
David: Nancy, in terms of the current committee, uh, how many primary consumer groups do we have represented?
Nancy: [unintelligible] Uh, I'll just read through quickly the groups we have represented, okay? Department of Children and Families, NAMI Florida, Brain Injury Association of Florida, National Association of Social Workers, Florida Psychological Association, Florida Psychiatric Society, Florida Alcohol and Drug Abuse Association, Florida Department of Law Enforcement, Church Street Counseling Center, Mental Health Association, Florida Drop-in Center Association, Pathways, Public Defender, Florida Hospital Association, Florida Consumer Action Council for Mental Health, Inc., um, The Drug Czar, uh, Certification, Board of Addiction Professionals, Florida Coalition for the Homeless, Florida Association of Child and Family Agencies, Medicaid Program Development, uh, Florida Department of Education, and another NAMI Florida.
David: Go ahead.
Pam: I was just thinking. I don't think I heard a single um individual group that is strictly clients, individuals with mental illnesses. I think the closest one was NAMI, which is um families and…
Man: Major Consumer Action Council.

Pam: Did it make it? Okay.
Man: Yeah.
Pam: I did miss that one then.
Woman: Drop-in Association.
Pam: Was that in there? Okay.
Man: The Florida Drop-in Association.
Pam: So that makes it two out of the whole group? Three?
Gwen: David.
David: Yeah, I'm sorry Gwen.
Gwen: What about the Manic Depressive Society Association?
Man 3: Some guy somewhere: They were invited.
Gwen: Were they on the list?
David: The Depressive – Manic Depressive Association was invited, and we're following up with them. It's hard for me to imagine that they wouldn't want to be part of this.
Gwen: Yeah. Mhmm. A lot of consumers in that.
David: Yeah. I think the Depressive – Manic Depressive Association would certainly qualify as as composed of primary consumers.
Pam: Is there any way of getting a consumer from the state hospital from a state hospital that could give us the viewpoint from there. I think that would be important to include.
Man: Sure.
David: Why don't we, and, we'll note, because I think what we want to do is see how the advisory committee structure filled out and it's filling out and there are some groups, but I hear. The sense I'm getting from the commission is that we need more. Primary consumers of mental health and probably primary consumers of alcohol and substance abuse services as well would be my guess. Um, why don't I ask you all to suggest to Nancy names of either organizations or individuals who you feel adequately represent the perspectives because I agree with you, and I'm not seeing anyone disagree about the fact that we want this report to very much be embraced by and be representative of the positions of those groups. Uh, and we can invite several more individuals into our groups to join, and we'll redouble our efforts with the Depressive and Manic Depressive Associations. So, can I ask you to do that? Do you know of particularly effective spokespersons for those constituencies? Um.
Nancy: Let me know.
David: Let Nancy know, and we'll invite them to become a member of the advisory group. Good. Thanks Dan. Any old business? [Pause.] Uh, Michael Spellman has requested under new business to make a motion.

Michael.

Michael: I talk loud [unintelligible] Uh, I started thinking about the kind of information we'd be and what kind of information we're going to need and the narrowness of our time frame. Uh, I'm really impressed by how little financial data we've looked at. And, when I stop and think about trying to translate some of the output of this commission into real legislation that that financial data is going to be real important.

Uh, I took the liberty of putting together. Actually, I made copies. Want to pass these out. Of putting together what struck me as critical data.

And, I assume it will take DCF a fair amount of time to to organize this much information, so basically the motion is that the commission adapt the following proposal, and I'll just read the preamble, which is "In order to make recommendations that are data based and consistent with fact, the commission calls for the following data and information to be provided by the Florida Department of Children and Families no later than April 14, 2000. The data should be provided in summary form with the raw data provided as appendices." And, I broke things down into three main sections: cost of care, uh quality of care, and then state resources. My concern is that if we wait a whole bunch longer uh and don't have this data available to us, we won't be able to use it and will be making recommendations that are theoretically good and financially unattainable.

Man: I'll second the motion.

David: Discussion?

Woman I think this is great Michael. I think we might want to talk about adding to this the monies that are funded through the Juvenile Justice as well as the Criminal Justice System for those uh individuals who end up in corrections regardless of age because of their mental or substance abuse issues.

David: And, I think what'll happen tomorrow, Michael, when you see. I think you're tracking exactly what we want to do. Because when we're talking about this resource committee, what we've been working on to this point and time is using the National Co-morbidity Study for Adults uh in some I think reasonably sophisticated ways to desegregate to the county level our estimates of prevalence by disorder type. But, what we don't have is the corresponding resource side of that to see how much is being spent by the various sectors that spend money. That's sort of the next phase of the work is to start cataloging that. So, I think that sort of anticipates that very nicely, but I very much would like for us to take a look at estimates at how much is money is spent in primary care for example to work on

alcohol and substance abuse issues, how much is spent in Juvenile Justice and the Department of Corrections and jails and prisons. There's going to be a data collection task that the commission and our staff should be involved in in terms of doing that, and I think that this anticipates this very nicely and will probably be in our first work group. So, great minds are in the same gutter here I guess or whatever the expression is. It's been moved and seconded that we forward this request to uh to uh DCF uh there has been a friendly amendment that it be expanded. Um, could I suggest another friendly amendment in that this motion be forwarded to our subgroup on needs and resources and that they craft a specific uh using this as a template that they craft a specific request to the appropriate state and local agencies to assess the resources that are used for the uh treatment of substance abuse and and mental health problems.

Michael: Are we going to have that subgroup organized this weekend or this week?

David: Uh, yeah, we're going to hopefully ask for volunteers tomorrow right after Kevin gives his brief presentation. We want to see how many people would like to work on the needs and resources part of it. Cause my sense is your sense is we gotta get going.

Michael:Yeah.

David: I agree.

Michael: Yeah, if we have it within this week, I'm fine with that.

David: Okay. So, essentially, amended the motion uh so that this becomes a template that will be given to the this resources work group that will be staffed by if you all are agreeable, Dr. Kevin Kip, who is the staff epidemiologist from FMHI. Uh and that they will uh working together craft the request to the appropriate government agencies both state and local to uh help us catalog resources that are spent for the uh treatment of uh persons with mental or addictive disorders.

Michael: Actually, I'm fine with that with a but. I'm fine with that but…

David: Yeah.

Michael: provided that all the data that are requested here at minimum be included.

David: Be part of that. Okay, I think that's fine. Any other discussion? [Pause.] All those in favor of the motion as amended say, "Aye."

Group: Aye.

David: Oppose, "Nay." [Pause.] Motion carries. Our final bit of business that we have. I'm sorry, Michael, go ahead.

Michael: While I'm on a roll, can I add a piggy back to that?

David: Can you add a ?
Michael: A piggy back motion.
David: Yeah.
Michael: Uh, it's also a resource issue, and I think it's more DOE. I'm not even sure who in the government exactly controls this, probably DOE. I'm also concerned about the use of trained professional resources throughout the state. Uh, I'm struck as I put out a request for uh employment applications how many people are applying for employment. We seem to have a uh wealth of qualified professionals many of whom are trained with state dollars, so if that work group could also attend to how much of our money is going into training and how many of these people are actually working in behavioral substance abuse fields.
David: Yeah, my guess is we will look at the health resource files and if the files from the licensure department – the Department of Licensure and Regulation – to get a sense of about what sort of the provider capacity is for the specialty disciplines, and that will be I think that will be an important part of the equation, Michael, for sure. This is going to be really complicated when we start to get into it, but it's very important. I think what it will do is it will help bolster these notions of unmet need to embrace not only the department's resources but the full state and local resources and then get to your notion, Terry, about how focused are they, how accountable are they, what are the quality of service provided in those settings. Get us into a different type of discussion of the de facto mental health system as opposed to the sort of specialized mental health system. Good. Thank you, Michael.
Michael: Thank you.
David: That's very helpful. Um, our next meeting is scheduled to be on March 31 in Tallahassee, and we had hoped that this meeting, tonight, Howard is going to do a state of the science for us in mental health. And, we had hoped to do the same um sort of thing uh on the uh 31st on alcohol and substance abuse. And, we had arranged for uh Jim McDunna to uh attend that meeting. Jim's the Drug Czar, the person who's charged by the governor to coordinate uh the various uh treatment and enforcement efforts. And, Jim's going to be able to join us. Now, the other person we wanted to have join us then was Dr. Alan Leschner who's the director of the National Institute on Drug Abuse, who like Howard is very engaging speaker, extremely knowledgeable, um, and unfortunately, Dr. Leschner can't be with us on the 31st. Um, but, we found out late Friday the dates when he could be with us, and there's a second questionnaire in your pile

of little questionnaires, and you'll see that there are several dates noted there. And, those are dates that Alan Leschner can visit with us.
Now, several people have expressed including Ken the fact that they would really like to have Alan down here if at all possible. Um, so, if it's your sense also that you would like him to attend. Um, he could come to one of the later meetings. My my sense was we wanted to get these issues on the table as soon as possible so that they would inform everything else that we did, so the sooner rather than later would be would be better. So, we've given you several dates there uh to consider. Can you just please mark uh your availability on each of those dates and hand those in with the other questionnaire that we circulated to you. Uh, and we'll check with Mr. McDunna's office um, and we'll move forward on that. What I'm probably going to try to do if it's okay with the commission is to try to move the elder mental health issues, the the one focusing on elder mental health. Our our thought was our proposal to you a couple uh meetings ago given that elder mental health issues are featured in our charge it would be important that and given that there are several interesting and important issues some of which Howard will talk about. Others of which Alan will may talk about that we wanted to have a special session focused on with focused testimony on issues of elders. Um, if that's still is our sense, we've not discussed this a lot, what I'm going to try to do if it's okay with you is to have that March 31 meeting uh focus on elder mental health issues um unless…is March 31 one of the dates we're asking you to indicate your…What? Yeah, okay. Then we're talking at the end of April. We're trying to move something up. Okay, good. Alright. I'm sorry. I had forgotten about um. Anyways, so, is that okay with you? I would very much appreciate uh your suggestions about who would be particularly knowledgeable to talk about this.
The person that I'm considering inviting and this only came up last week uh is a former is actually the first director on the National Institute on Aging, uh a geriatric psychiatrist who's currently heading a center on longevity at Mount Sinai Hospital. Um, and I don't know if any of you, I want to say Sullivan is his name. I don't remember his name. Do you Aaron? The NIA director? Uh, but I need to look into this a little bit a little bit further in terms of someone who could really get us state of the art elder mental health issues. There's all kinds of epidemiological issues, we'll see those tomorrow. The NCS data indicates lower prevalence for older populations, and and the elder advocates certainly feel that that higher prevalence is what's indicated. Alright? Is everybody as warm as me or is just because I'm standing up? Okay, we're trying to

get the air conditioning turned down a little bit, but, Michael?

Michael: If you're going to go to uh a geriatric focus for that next meeting, do we need to invite Secretary Hernandez?

David: Yes, we will definitely invite Secretary Hernandez, and since we're going to be in Tallahassee that will probably increase the likelihood that she'll be able to attend. Yeah. Because I know she's very aware and interested in alcohol substance abuse and mental health issues and extremely supportive, so yeah, we will invite her for sure.

Okay, any other, uh, new business? I think we've covered everything and we're only about half an hour late, which isn't too bad. We're done.

End Session 1

Appendix C. Ruth's Transcript

Ruth Thank you very much. Um I apologise for putting my professional credentials on my introduction yet JD MBA CPA I am a lawyer and I apologise for that [laughter] I have an MBA and a CPA also and I apologise for that as April 15th is coming um and those credentials um I have to say I will usually include when I speak as a family member simply because people may attention more to lawyers and CPAS and I'm sorry and I apologise for using those credentials to get me a place on the agenda but nevertheless if they'll work I'll use them.

I want to thank you to the Commission I have not ever worked on such a positively monumental task As I look at your faces today I know it it must be overwhelming. I reviewed the executive summary of the Surgeon's General report and I applaud the effort um unlike Dr. de la Torre, I am able to say that the Surgeon General didn't say one thing that I want to say today so the things that I am going to say are going to be quite different than the statistics that you have been reading so far. My real credentials for being here today are as a family member um it's a f word that a lot of people don't want to deal with. For so many years family members were ignored and our input was not valued at all and I am happy to see that this is currently changing. Um my family members I have two children.

My older son Patrick is coincidently a senior at the medical school at the University of South Florida and he is finishing there and I tried to get him to go into psychiatry and he would have none of that.

My younger son Christopher is twenty-four and he suffers from chronic paranoid schizophrenia and right now he is thank god at the Northeast Florida State Hospital at McClenny just so that you will appreciate I am equally proud of both of my children Patrick, for those of you who are physicians 278 on the last level of the MSLE which is the 99th percentile for students taking the uh board exams in medical school and Christopher I am proud to say um when he was at the Northeast Florida State Hospital his last go-round got his high school equivalency and while that may not seem like much to you my older son told me "you know for Christopher to get his GED was just as difficult for him as getting my med school degree as for me." And when you have a brain disorder like schizophrenia that is a thought disorder this is absolute truth. That getting his high school equivalency is just a major miracle.

Now with that in mind I do have to say that I really am equally proud of both my children uh I have to say my older son has been easier to deal with my younger son has been more difficult. But with those credentials in mind I do want to say that what I do now as a volunteer and I'm not being paid to speak here and the main thing that I do that I think is my best work is not the work I do at Jacksonville University I am proud of that too but as an advocate and someone who tells it like it is from the

Let me tell you a brief history of the things that don't come out in the Surgeon's General report on the trauma on the family as well as the person who suffers from mental illness. My child was hospitalized at the age of thirteen at the age of fifteen then at the age of seventeen and he was hospitalized for schizophrenia and he was in the hospital the last go-round for twenty-nine days. He was discharged on a Friday afternoon

came home depressed with the diagnosis depression. I on the other hand had some deep inkling that schizophrenia was the correct diagnosis. He went downhill all weekend. Monday called the doctor and said change the medication do anything. He changed the medication fortunately to Haldol which is an obsolete in many ways generation of drugs and on Tuesday my I saw my child before my very eyes turn into someone I didn't know. That's the way it is sometimes with. schizophrenia Christopher is a peace-loving child he would rather flee than fight. He attacked my husband and me because later he was able to tell me that he truly believed that we trying to kill him. Parents who loved him. And I am happy to say that we called 911 and 911 responded very quickly. My husband and I escaped through the back door and locked Christopher in the house, walked up to the front, and escorted the police officers into the house and as my husband and I were walking up the front steps he turned to me and said "I'm going to collapse" and he dropped dead of a heart attack. On the spot (audible tremor in her voice). So I know firsthand the trauma of losing a family member directly to mental illness. And my son thank god the police took Christopher to University Medical Center where after a long time he was correctly diagnosed with schizophrenia. I am infinitely grateful that the police were taking my child out to the hospital and not taking him to jail because it's a much better place for someone with schizophrenia. That started a very long list of hospitalizations and I could go through the number of days he was there but needless to say but to me the most improvement I saw in my child was when he stayed at the Northeast Florida State Hospital because he was there long enough to be able to recover and it is an exhausting and traumatic illness. Schizophrenia takes a huge amount of time to recover from. So what I do now is to do the best I can with a system that is horrendous to deal with. The fact that I am a lawyer and the fact that I am a CPA has been an enormous help to me intellectually but not emotionally. So the thing I would like to leave you with is the two f words you can use from my perspective. One is family and family is good and the second is faces. And here is a picture of my family at my older son's wedding. The faces that are not here are my husband's and my younger son. Um and you know why. And here is another picture of faces that is a good one. This is the day that my son got his GED at Northeast Florida State Hospital and that is a very happy time and that is my mom and dad and Patrick and Christopher. And the other picture of faces is one that I hope you will remember and this comes from the family to family education course that I teach with Jean Silsbey, for the National Alliance for the Mentally Ill. These are faces - don't they look perfectly healthy? Of some of the children and loved ones from our families who suffer from different mental illnesses and this is just to remind you that as you get bogged down in all the paperwork and I don't have one handout for you as you get down in all that paperwork that that these are human beings and that we are humans and that is another f word to remember and that is face. And my calendar thing for the day today was just for today is poise and the saying was a good head and a good heart are always a formidable combination and that is from Nelson Mandela.

And the other thing that jumped out at me this morning was when I was thinking about humility and I went to my topical Bible came up with Matthew 25:37 and I have used this in speeches to church groups 'then shall the righteous answer him saying 'lord when saw we thee hungry and fed thee or thirsty and gave thee drink? When saw we thee a stranger and took thee in? Or naked and clothed thee? Or when saw we thee sick or in prison and came unto thee? And the King shall answer and say unto them (voice breaking, .3) verily as I say unto you inasmuch as you have done this unto one of the least of my brethren, you have done it unto me." Thank you.

Shern That is certainly a very poignant series of remarks and it is very important and I think that we as a Commission continually impressed by the primary voices of people who have mental illnesses and their family members. So Ruth, thank you very much for sharing that. [time 28.36]

ABOUT THE AUTHOR

Ardis Hanson earned a Bachelor of Fine Arts from the University of Tampa and a Master of Library Science from the University of South Florida. She has over seventy publications in the areas of mental health services research and policy, virtual libraries, geographic information systems, health informatics, and communication.