Virginia Commonwealth University
VCU Scholars Compass

Theses and Dissertations | Graduate School

2012

The Multiple Perspectives of the Lived Experience of Civil Detainment

Linda Love
Virginia Commonwealth University

Follow this and additional works at: https://scholarscompass.vcu.edu/etd

 Part of the Social Work Commons

© The Author

Downloaded from
https://scholarscompass.vcu.edu/etd/2900

This Dissertation is brought to you for free and open access by the Graduate School at VCU Scholars Compass. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of VCU Scholars Compass. For more information, please contact libcompass@vcu.edu.

www.manaraa.com

Copyright Page

© Linda E. Love LCSW 2012
All Rights Reserved

www.manaraa.com

The Multiple Perspectives on the Lived Experience of Civil Detainment:

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

by

Linda E. Love MSW, LCSW, PhD Candidate

Director: Mary Secret, PhD
School of Social Work

Virginia Commonwealth University
Richmond, Virginia

www.manaraa.com

www.manaraa.com

Acknowledgements

"I could not, at any age, be content to take my place by the fireside and simply look on. Life was meant to be lived. Curiosity must be kept alive. One must never, for whatever reason, turn his back on life."
Eleanor Roosevelt

Thanks to:
Bobbie, Taylor, Autumn and Summer for their patience, support, and comfort while I sat for hours with this dissertation trusting that I would return
Mary C. Secret for pushing me to clarify and define my thoughts as well as for her patience when I pushed back versus embracing her wisdom
Mary Katherine O'Connor, for believing in me over the multiple decades
Kia Bentley, for developing a supportive cohort and a community of learning
Michele Nelson for stepping in during the ninth inning and being a supportive colleague
My mom and dad –for it all

www.manaraa.com

Dedication page

For the passionate souls who endure this process – both as the individual detained and individuals involved in the detainment.

www.manaraa.com

Table of Contents

www.manaraa.com

www.manaraa.com

www.manaraa.com

www.manaraa.com

www.manaraa.com

Abstract

Civil detainment can be confusing, frustrating, and scary especially if the criteria for civil detainment are being applied inconsistently. A constructivist inquiry, using qualitative techniques as the primary information gathering method, was conducted to gain a better understanding about the experience of civil detainment. Twenty-five stakeholders participated in this research effort. Questions regarding the meaning of civil detainment were explored in five stakeholder groups; individuals with mental illness, families, mental health professionals, first responders and judicial professionals. Civil detainment is described as a "necessary evil" however, mandated treatment is also described as a means to restore dignity. Implications are included for social work practice and policy. Recommendations for future research are identified.

Keywords: Social Work_ Civil Detainment_ Mental Illness_ Policy _Constructivist Inquiry

www.manaraa.com

Chapter 1: Introduction

Civil detainment is the restriction of an individual's liberty by a government entity for a non-criminal offense (Appelbaum, 2002; Bay, 2006). In the Commonwealth of Virginia, a civil detainment involves an emergency custody order (ECO) and possibly a temporary detention order (TDO). The ECO allows an individual with mental illness and considered potentially dangerous detained up to six hours. If the individual is found to be in need of an evaluation for ongoing mandated treatment, the individual with mental illness is temporarily detained (TDO) for up to 72 hours while awaiting a civil commitment hearing. Finally, if the individual needs further treatment and is unable or unwilling to agree voluntarily to treatment, a civil commitment hearing can be initiated and the individual can be committed to a psychiatric treatment facility for a period of 30 days.

The policy as of July, 2008 for civil detainment in the Commonwealth of Virginia stated:

> Any magistrate shall issue, upon the sworn petition of any responsible person, treating physician, or upon his own motion, an emergency custody order when he has probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment (Department of Mental Health Mental Retardation and Substance Abuse Services, 2008).

Civil detainment can be confusing, frustrating, and scary especially if the criteria for civil detainment are applied inconsistently. This inconsistency can make the process frustrating for the individuals who are detained, the clinicians who treat the detained individual, and for the other stakeholders. When people are detained without meeting the criteria for detainment, the

www.manaraa.com

process can be seen as arbitrary and authoritarian. This experience can be frightening for the individuals who are being detained. Moreover, it can be frustrating for the clinicians who have knowledge of the client's full mental health history that suggests that detainment criteria is not present.

As a mental health clinician, I experienced the full magnitude of these emotions in August of 2008 when a client of mine was detained in a psychiatric facility for four weeks. Prior to this time, I had been actively involved in a number of crises that involved civil detainment. However, I had never before experienced the level of difficulty with the process as I did in this case.

In the Commonwealth of Virginia under the newly enacted 2008 civil detainment law, a pre-screening assessment performed by a specialist trained and employed by the Community Services Board (CSB) was compulsory prior to the initiation of a civil detainment order. In this case, I received a call from a pre-screening evaluator representing the CSB who identified herself as a clinical social worker and asked if I was the therapist for Alice (pseudo name). When I affirmed that I was, she proceeded to tell me that she would be detaining Alice for a psychiatric assessment for mandated psychiatric treatment. The criteria for Alice's civil detainment were that she had a mental illness and was in danger of hurting her husband in the near future. I had seen Alice for an individual therapy session two days prior to this call. At that time, she had not met the criteria for civil detainment, so I was surprised by this information and was concerned that there might be an error.

Alice was a 48 year old mother of two. Married for 20 years, she was a homemaker who cared for her two children and her husband. In 2006, she had been evaluated for medications by a psychiatrist, diagnosed with post-traumatic stress disorder and bipolar disorder, and prescribed

www.manaraa.com

psychotropic medications. She entered treatment with me in that same year verbalizing a desire to work on decreasing the impact of the mental illness on her life. She reported that she had periods of dissociation, mood swings, and impulsivity. In particular, she indicated that she had a lot of anger toward her past abusers and her current husband.

Two weeks prior to the CSB prescreening, Alice's oldest daughter, age 16, had overdosed and died at home by ingesting a number of medications and other unknown substances. The pre-screener stated that Alice's family had contacted the CSB, the police, a lawyer, and the Department of Behavioral Health Services and reported that Alice was a danger to herself and her family. Apparently, she had expressed a desire to her neighbors to hurt her husband. Her husband had found journals in the trunk of her car that noted Alice's desire to kill him. In addition, he found medications of varied quantities hidden in a bag in the trunk. Lastly, while cleaning out his daughter's room, the husband found a gun hidden behind the daughter's bed.

On one hand, I could understand the concern and fear given the recent events that had transpired. Alice had a history of verbal aggression towards her husband; she was trained in using a firearm; and her mental illness caused her to be impulsive at times. With the additional evidence of the journals, the recent death of her daughter, the report from the neighbor, and the bag of pills, it appeared that Alice was in danger of hurting her husband.

On the other hand, I had seen Alice for over two years. Although she spoke frequently of her anger with her husband, at no time had she indicated that she was going to follow through on her threats to kill him. Alice had been able to contract for safety with me each time and had a safety plan in place to use if she felt that she was unable to honor the contract. In addition, at no time in the two years that she was in treatment with me had she committed any violent acts

www.manaraa.com

towards her husband or anyone else. She had a history of utilizing journaling to channel her angry feelings appropriately, but had made no entries in the last 6 months.

After her daughter's funeral, Alice and I spoke over the phone twice. We met for a full individual therapy session two days prior to the call from the pre-screener at which point I assessed her mental status. At that time, I determined that she was emotionally fragile but was future oriented and willing to remain in treatment. During that session, she reported that she was angry with her husband for his lack of emotional response to their daughter's death. She did not express a desire to kill him. In fact, when they arrived to execute the civil detainment order, she had spent the day shopping with her younger daughter and cleaning up after her dinner.

My clinical information based on Alice's mental health history suggested that a threat to kill her husband was unlikely and I expressed my willingness to assess her on the next working day. Nonetheless, she was taken from her home in handcuffs, transported by police to the CSB, and evaluated for mandated psychiatric treatment.

I contacted Alice once she was admitted to the hospital and spoke with her at length about the events of the previous two days in an attempt to ascertain why she was considered dangerous. I also spoke to the hospital staff, the psychiatrist, and the assigned social worker. In my discussions with them, Alice and the staff were unable to provide any additional evidence beyond the neighbor's report that Alice was dangerous. The only criterion for Alice's detainment appeared to be that she had a severe mental illness; nonetheless, she was deprived of her liberty. The experience became even more confusing as the days went on.

At the time of Alice's detainment in August 2008, the law in the Commonwealth of Virginia stated that an individual could be detained if he or she was considered dangerous due to mental illness and was likely to become dangerous in the near future. The information that I had

www.manaraa.com

about her current mental status while on the unit led me to believe that Alice was not a danger to herself or others. She had not presented any aggression, verbally or physically. There had been no verbal threats to her husband, hospital staff or myself. She was willing to continue treatment upon discharge. Given that the criterion of "substantial likelihood of danger in the near future" had not been substantiated, I was confident that Alice would be released once the civil detainment hearing was held. However, Alice was not released.

During the commitment hearing, her husband's private lawyer introduced evidence of reports by the neighbors that Alice had threatened her husband, of the presence of the gun in the home, of the threatening journal entries made 6 months prior, and of her severe mental illness. She was committed to the psychiatric hospital for mandated treatment.

I remained in contact with her and conducted therapy sessions with her in the hospital throughout the mandated detainment stay. At no time had Alice demonstrated suicidal or homicidal ideation or threatened any acts of violence beyond the hearsay reports made by her neighbors. Alice was detained in the hospital for another three weeks. I experienced a sense of helplessness; in spite of my efforts to advocate on her behalf, she was not released.

Finally, Alice requested a patient advocate from the hospital. Only then did her situation begin to change. Within 24 hours of receiving a patient advocate, Alice was released. I wondered if the patient advocate was able to substantiate that there was no evidence that met the standards for the civil commitment within the 2008 civil detainment legislation. For the next two years, I continued to treat her on an outpatient basis, intermittently when she returned to the area. During that time, she committed no acts of violence.

Alice's experience motivated me to investigate the civil detainment policy in Virginia. I found that the legislation governing this policy had recently changed in July of 2008. These

www.manaraa.com

primary changes involved (a) a shift in timeframes for the determination of danger from "in the imminent future" (24 hours) to "in the near future" (7 to 10 days) (Cohen, Bonnie, & Monahan, 2008, p.2), (b) an alteration in the definition of the level of dangerous from "imminent danger to himself or others" to "substantial likelihood that . . . he or she will cause serious physical harm to himself or others…." (Cohen, et all., 2008, p.7), (c) the clarification of an individual's civil rights (Cohen, et. al, 2008, p. 10), (d) a greater specificity about the language of unable to care for self (Cohen, et. al, 2008, p.11), and (e) a more restricted range of professionals and organizations involved in the civil detainment decision making process (DBHDS, 2008).

During the course of my dissertation research, described in subsequent chapters, I became more and more aware of the differing values about safety, security and mental illness that impacted the implementation of the new 2008 civil detainment legislation.

The Impact of Values on Civil Detainment

My experience as a mental health clinician and the dissertation literature review illuminated that values impact the phenomenon of civil detainment. In this dissertation, 'values' refers to beliefs or opinions that guide preferences about appropriate courses of action or outcomes in particular situations (Porter, 2010). I realized that in order to deepen my understanding of the most recent civil detainment policy, it was crucial to understand the values that were serving as guidelines or influencing behaviors pertaining to civil detainment in the past.

In addition to values, I found three major constructs critical to understanding the experience of civil detainment post 2008: social contract theory, civil detainment policy (which included the definition of mental illness and dangerousness), and the multiple perspectives involved in the implementation of civil detainment legislation. For individuals subjected to civil

www.manaraa.com

detainment, these constructs intersected with each other in multiple ways to create unique experiences pertaining to recovery, dangerousness, and dignity.

The impact of civil detainment on an individual's life has received relatively little attention in the scholarly literature. Even less is known about the actual experience of civil detainment through the lens of the individuals involved subsequent to the 2008 legislation. Such information would be valuable to social work practitioners, policy advocates, and anyone involved in caring for individuals with mental illness. With a deeper understanding of the subjective experience of the individuals involved, legislative changes can be pursued and improvements made in the treatment offered to individuals with mental illness that would promote recovery.

The Statistical Profile of Civil Detainment in the Commonwealth of Virginia

The Commonwealth of Virginia reported approximately 750 emergency custody orders (ECO) and 19,522 temporary detention orders (TDO) in fiscal year 2011 (Commission on Mental Health Reform, 2011). The number of TDOs has increased since the 2008 reforms went into effect. The Supreme Court's eMagistrate database reported that the numbers of TDOs in almost every month of FY09 were higher than during those same months in FY07 (by an average of 11.7%) and FY08 (by an average of 5.9%) (Commission on Mental Health, 2011). The numbers of TDOs in the first half of FY10 were also higher than the same months in FY09 (an average increase of about 6.5% for those months) (Commission on Mental Health, 2011). One reason for the jump in statistics may have been due lack of uniformed data collection methods and faulty data reporting. Another reason may have been an increase in civil detainments because of the new 2008 legislation (Commission on Mental Health, 2011).

www.manaraa.com

The Relationship between Social Work and Civil Detainment

During the course of my dissertation research, I also explored the relationship between social work practice and the civil detainment process. Social work is a value-based profession with a "mission to enhance human wellbeing and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, and oppressed" (NASW, 2011, para. 6). Individuals with mental illness are considered vulnerable because they are often unable to help themselves or advocate for their needs. They have been more susceptible to poverty, victimization by others, and often have poor outcomes for co-morbid physical illnesses (World Health Organization, 2003). In particular, the individual with mental illness experiencing civil detainment has been even more vulnerable as the individual's autonomy has been removed and his/her power delegated to professionals involved with the detainment process.

Social workers have maintained a critical and integral role in the process of civil detainment and have been involved in the civil detainment experience in a number of ways both pre and post the 2008 civil detainment legislation. In the Commonwealth of Virginia these roles have included a number of responsibilities which are carried out in various organizations. For example, an emergency services social work clinician for an area CSB has the power to determine whether an individual is in need of civil detainment. As a licensed clinician in private practice, a social worker may initiate the civil detainment processes for clients who may be dangerous to self or others. Finally, a social worker within the psychiatric hospital may have the task of conducting evaluations and making recommendations to judges about whether a civil detainment order needs to be extended.

www.manaraa.com

Throughout my career, I have had experience with all aspects of the civil detainment process. Thus, I was concerned about the possible inconsistencies in the ways the recent 2008 policy was applied in Alice's case. I found, through this dissertation journey, that multiple stakeholders' values and perspectives, inconsistencies in the interpretation and implementation of the civil detainment policy, and inconsistencies in the application of civil rights influenced and reflected Alice's experience.

Summary

My professional experiences and commitment to the social work profession, plus the dearth of relevant literature on the most recent civil detainment legislation led me to see the need for research on the lived experience of civil detainment post 2008. Exploring civil detainment through the lens of individuals involved in the experience meant conducting research within the context of their experiences. In order to conduct useful research within the context of civil detainment experiences, I chose a constructivist methodology within an interpretivist paradigm. The flexibility of a constructivist inquiry allowed me to explore multiple realities and the influence of those realities on the experience of civil detainment.

The following chapters present the exploration of the primary question: "What are the multiple perspectives on the lived experience of civil detainment in the Commonwealth of Virginia subsequent to July 2008?" Chapter Two examines the literature surrounding civil detainment and social contract theory, civil detainment policy (including the definition of mental illness and dangerousness), the multiple perspectives involved in the implementation of civil detainment legislation,. Chapter Two also presents the working hypotheses and the conceptual framework. Chapter Three outlines and describes the research that I conducted. Chapter Four presents the case report that is a joint construction of the experiences of civil detainment by all

www.manaraa.com

individuals interviewed. Chapter Four also introduces the tentative lessons learned which, in Constructivist Inquiry, are lessons that I garnered from an analysis of the word data offered by the participants and my experiences during the inquiry. Finally, Chapter Five examines in more detail the tentative lessons that I learned or came to know and the implications of these lessons for policy, direct practice, and research, and education. The dissertation as a whole documents my journey into a deeper understanding of civil detainment.

www.manaraa.com

Chapter Two: Understanding Civil Detainment

Civil detainment has not been extensively discussed in the scholarly literature; even less information was available about civil detainment specific to the Commonwealth of Virginia. Nonetheless, I endeavored to explore, as thoroughly as I could, the constructs, assumptions, theories, and empirical investigations associated with civil detainment – whether in medical, behavioral, social science, or legal disciplines and within the general literature as well as that specific to the Commonwealth of Virginia. The goal was to deepen the understanding related to the complexities of civil detainment as identified in the literature and to situate the inquiry in the "ongoing discourse about the topic" (Marshall & Rossman, 1999, p.22).

This chapter first discusses the constructs of social contract theory, civil detainment policy, and the multiple perspectives involved in the implementation of civil detainment legislation. Next, the chapter examines the diversity of values and perspectives among the individuals involved in the civil detainment experience. The chapter then presents the social constructivist theory that influenced the research methodology followed by the emerging research question and the conceptual framework that depicted the connections among the major constructs. The chapter concludes with the working hypotheses and the foreshadowed questions that guided the inquiry.

Social Contract Theory

Social Contract Theory (SCT) emerged from the idea of a contractual agreement between an individual and the state. This hypothetical social contract outlined the state's justification of its sovereign power and induced individuals to agree to obey the law in every matter in exchange for a guarantee of security and peace (US Legal, 2012). It has been an implicit agreement among

www.manaraa.com

members of a particular society of self-interested and rational citizens as a way to develop and maintain a structure for peace.

Socrates first discussed the existence of a social contract when he explained why he must remain in jail and await his death versus escaping and living in exile. Socrates believed that the laws of the government allowed him life. Thus, in exchange for his life, he agreed to abide by the government's decisions. This was, in essence, an implied social contract for peace and security (Friend, 2006).

In the 1600s, Hobbs advanced the understanding of the SCT by asserting that human beings agreed to the contract because the alternative was a worse plight. By residing in the particular society, citizens agreed to abide by the rules of the society in exchange for the ability to function autonomously and with liberty in that society. Hobbs' social contract theory added the existence of a dictator whose responsibility was to govern the citizens' impulsive, selfish and wantonly desires. This dictator, embodied in the form of government, had the power to restrict an individual's autonomy and liberty as an aspect of citizens' compliance with laws (Friend, 2006).

According to Hobbs, the implied contract was applicable to all individuals except people with mental illness (Friend, 2006; Gauthier, 1986; Rawls, 1971). If an individual was unable to conform to the laws of the land due to his or her mental illness, his or her ability to remain autonomous, contribute to, and/or function in a society was jeopardized. This position of vulnerability increased the government's responsibility for assuming care and welfare for the individual. Like the parent in the family, the government, under Social Contract Theory, was able to intervene into or limit the individual's autonomy and liberty to ensure the safety of the individual and family.

www.manaraa.com

In *On Liberty*, Mill clarified that autonomy and liberty were *prima facie* rights accorded to all citizens except for children and persons with mental illness. Individuals with mental illness were exempt from the assumption of autonomy and liberty because they were viewed as suffering from mental incapacity. It was believed that their illnesses affected their ability to be rational in comparison to others in the community. Thus, an individual suffering from mental illness was considered irrational and incapable of maintaining society's social contract resulting in a broken social contract. The result of a broken social contract was that the government could then restrict an individual's autonomy and liberty to ensure the safety of the entire society.

This position of vulnerability increased the government's responsibility for assuming care and welfare for the individual. Like the parent in the family, the government, under Social Contract Theory, was able to intervene into or limit the individual's autonomy and liberty to ensure the safety of the individual and family. This action by the government has been considered paternalistic as it assumed the responsibility for the care and welfare of the individual with mental illness (Friend, 2004; Gauthier, 1986; Mill, 1959; Rawls, 1971).

Paternalistic practice in healthcare has been the act of conferring treatment on a person due to his or her diminished capacity with the aim of avoiding harm and doing good (Beauchamp & Childress, 2001; Cody, 2003). Civil detainment has been one such paternalistic practice that has often been in conflict with an individual's liberty and his or her ability to make personal choices about psychiatric treatment (Hiday, 2006; Prinson & von Delden, 2009).

Civil Detainment Policy

Rooted in social contract theory, civil detainment is a policy that allows the government to restrict the liberty of an individual with a mental illness in an effort to protect both the individual (*parens patrie*) and the community (police powers) (Anfang & Appelbaum, 2006; La

www.manaraa.com

Fond, 1994; Musters, 2010). The intent of the policy has been to ensure safety of the community while protecting the right to liberty for the individual with mental illness who was not dangerous. In other words, because the policy specified the circumstances under which an individual's liberty could be restricted, it protected the liberty of individuals with mental illness who were not a danger to the community. The tension that exists between the liberty of an individual and the safety of a community has remained a central issue in the debates about civil detainment (Anfang & Appelbaum, 2006; La Fond, 1994; Musters, 2010).

Security for the community. According to Stone, (1998), security has been defined as the sense of safety and protection from danger. Security of the community has overridden an individual's right to liberty to do as he or she pleases if that individual was perceived to be dangerous due to a mental illness. The only lawful reason for exercising power over any member of a civilized community against his or her resolve has been to avert injury to others (Stone 1998). From the utilitarian perspective, the "morality of coercive treatment was determined by the extent to which it serves the greater good of the individual, society or both" (Swartz, Burns, George, Swanson, Hiday, Borum, & Wagner, 1997, p. 35).

Liberty for the individual. Defined as freedom from physical restraint or arbitrary control of others and serving as protection from unwarranted government intrusions (Lawrence v. Texas, 2003), individual liberty has been a core principle undergirding this nation. Furthermore, Abraham Lincoln (1864) defined liberty as the ability to "do as one please with one's self or with one's possession or product of one's labor" (p. 302). Deprivation of liberty in the form of civil detainment has ranked among the most serious restrictions on an individual's freedom imposed by state government (Mill, 1959, 1993; Morse, 1982).

www.manaraa.com

Thomas Szasz (1970) provided an additional perspective on civil detainment and individual liberty when he argued that no individual should be deprived of liberty unless found guilty of a criminal offense. In his opinion, depriving a person of liberty for his or her own good was immoral. Just as a person suffering from terminal cancer could refuse treatment, so should a person be able to refuse psychiatric treatment. The right to refuse treatment to maintain one's personal liberty and control personal autonomy has remained a heated debate in discussions pertaining to psychiatric advance directives, the right to refuse medications, and mandated outpatient treatment (Appelbaum, 1988; Bay, 2006; Lebensohn, 1999; Perlin, 2003; Willigenburg, 2005).

Restrictions of an individual's freedom imposed by state government has remained a highly contentious legal process. The stakeholders who campaigned for community safety over individual liberties advocated for the continued confinement of individuals who had a mental illness *"just in case"*. Not surprisingly, this 'just in case' policy led to misuses of detainment. The 1975 landmark *O'Connor v Donaldson* was a case in point. Mr. Kenneth Donaldson, a person with a diagnosed mental illness, was held 15 years in a mental institution in spite of the absence of proof that he posed a danger to himself or others (Ferris, 2009). Because of this case, the civil detainment policy was expanded to include the criterion of dangerousness. This added criterion helped to reduce the potential for this type of abuse as it detailed the boundaries as to what behavior or statement made by an individual would constitute confinement and restriction of freedom.

A major difficulty with the liberty for the individual aspect of civil detainment has always been the multiple interpretations of terminology such as "competency" and "prediction of danger". As discussed earlier, the premise behind civil detainment has been that the individual

www.manaraa.com

with mental illness was not competent to make the appropriate decisions to ensure his or her well-being or the safety of others. Unfortunately, the decision to detain an individual based on competency has not included the use of standardized competency testing. Rather, various individuals in the medical and legal community have conducted face-to-face interviews with the individual detained, observed his or her behaviors while detained, and then rendered an opinion about the competency of the individual (Kitamura & Takahasi, 2007). Given that a standardized competency evaluation has not been available, an argument has been made that an individual's liberty is being restricted without sufficient evidence (Kitamura & Takahasi, 2007). The Virginia 2008 legislation did not address this argument.

At the same time, protecting autonomy for the individual may be achieved by the use of civil detainment. Advocates for this perspective have argued that the individual's liberty and autonomy can be re-established with medications and/or therapy. The argument has been that treatment can restore the individual's liberty and autonomy due to the advancements in psychotropic medications, the increased knowledge pertaining to the neuroscience of mental health, and evidence based treatment (Appelbaum, 1988; Dubois, 2008; Green, 1997; National Alliance on Mental Illness, 1995, Satcher, 1999). According to these arguments, civil detainment has increased the potential of the individual with mental illness to reestablish his or her dignity and to regain self-determination and liberty (Appelbaum, 1988; Dubois, 2008).

Criteria for civil detainment. The presence of mental illness and the perception of dangerous have always been the two major criteria for civil detainment.

Mental illness. In my research, I found three different definitions of mental illness: a general legal definition, a legal definition specific to the Commonwealth of Virginia, and a definition in the medical literature. These three definitions have nuanced meanings. The general

www.manaraa.com

legal definition addresses behaviors and the impact of those behaviors. The Commonwealth of Virginia's specific definition includes the need for treatment as a criterion for detainment and the third definition focuses on mental illness as a medical condition.

Within the legal arena, Black's Law Dictionary does not define mental illness but rather states that mental disease or defect is synonymous with insanity (Garner, 1999, p.545). The test of insanity has been whether the individual has had the capacity to understand the nature of what he or she has done or has threatened to do (p. 545). The test of insanity has been whether the individual has had the capacity to understand the nature what he or she has done or has threatened to do (p. 545). This has been confusing as Black's Law Dictionary (Garner, 1999) also argues that the term "insanity" is a social and medical term and not a legal term.

The code of Virginia (2012) has amplified the general legal definition of mental illness. The code defines mental illness as "a disorder of thought, mood, emotion, perception, or orientation that significantly impaired judgment, behavior, capacity to recognize reality, or ability to address basic life necessities and requires care and treatment for the health, safety, or recovery of the individual or for the safety of others" (para. 51). Thus, in addition to the general legal definition, the Virginia definition addresses the need for treatment to ensure both the individual's safety and the safety of others.

The medical literature has defined mental illness as a disorder of the brain circuits caused by developmental processes and shaped by a combination of genetics and environmental influences (Insel & Wang, 2010). The medical definition has viewed mental illness as organic in nature as well as impacted by environmental factors. There is no reference to safety of the individual or the community in the medical definition.

www.manaraa.com

The debate over whether mental illness is of organic origin or a result of psychological or societal causes has continued (Gutting, 2008; Szasz, 1974). There has been difficulty with defining the exact nature of the illness because of the questionable influences of environmental and societal factors, i.e. co-morbid medical disorders increase the challenge of determining its origin. Beliefs about the causes and treatments of mental illness have continued to evolve, contributing to confusion and a tension between multiple definitions of mental illness (American Psychiatric Association, 1994).

Without clear direction, the ambiguity of terminology has left a wide range of potential interpretations and inconsistencies. Multiple interpretations of terminology emerged from fundamental differences about mental illness and differing values and perspectives of the legal and medical profession. Terminology such as "requiring care and treatment" or "lacking the capacity" found in the civil detainment policy has not clearly specified or defined which level of treatment was required or how the determination of capacity was to be made (Appelbaum, 2007; Appelbaum, 2008; McGravey, 2007).

Ultimately, the prevailing tool to understand mental illness has been the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM IV), a reference manual that identifies criteria for diagnoses based on the skills, experience, and perspective of the interpreter, e.g the one rendering the diagnosis (Chow & Cummings, 2000). Major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, and borderline personality disorder all have qualified as serious mental illnesses defined by the DSM IV. These illnesses manifest at various points on the spectrum of severity and are often influenced by life stressors such as death in the family, job loss, or physical illness.

www.manaraa.com

Similarly, mental illness has a direct impact on job acquisition, independent living, self-esteem, and self-efficacy of those who suffer from it (Corrigan, Larson, & Kuwabara, 2009; Link, 1982, 1987). Mental illness also has the capacity to affect negatively an individual's physical well-being by triggering stress-related illnesses such as migraines, hives, and other illnesses. Furthermore, according to the *Global Burden of Disease* study, mental illness can shorten an individual's life span by 15.4 years (Murray & Lopez, 1996).

Symptoms of mental illness have been both visible and invisible. Examples of outward manifestations of mental illness have included unexplained episodes of crying, outbursts of anger and aggression, impulsive behaviors, substance abuse, and chaotic interpersonal relationships. Less visible symptoms reported have included fatigue, auditory or olfactory hallucinations, paranoia, poor cognitive skills, suicidal or homicidal thoughts, and memory loss (American Psychiatric Association, 1994; USDHHS, 1999).

Understanding mental illness has involved understanding culturally specific biases and the impact of these biases on the illness (Bay, 2006; Loue, 2002; Radden, 2009). Thus, stigmatization, discrimination, expectations of recovery, and beliefs surrounding dangerousness figured prominently in the characterization of mental illness (Corrigan et al., 2002).

Dangerousness. A second critical criterion embedded in the civil detainment legislation has been the perception of dangerousness. Garner (1999) has defined danger as "jeopardy; exposure to loss or injury; peril" (p. 274). Danger as a criterion of civil detainment means "threatened and impending injury as would put a reasonable and prudent man to his instant defense" (p. 515). At the time of detainment, although a crime or harm has not actually occurred, there is a threat of danger.

www.manaraa.com

"Dangerousness" is multifaceted and needs to be understood within the context of several complex variables such as the perceived threat of danger, the history of violence, the severity of the mental illness, and the level of support in the community and in the home available to the individual with mental illness. However, recent studies found one significant and consistent risk factor indicating dangerousness: a history of threatening or violent behavior. This was the most critical indicator for future dangerousness (Amore et al., 2008; Warren et al., 2008). Other risk factors for dangerousness in relation to individuals with mental illness included medication noncompliance (Alia-Klein et al., 2007; Ascher-Svanum, 2006; Elbogn et al., 2007; Foley et al., 2005) and poor insight into the severity of the illness (Alia-Klein et al., 2007; Woods, Reed, & Collins, 2003).

Although there has been an association between having a mental illness and dangerousness, individuals with mental illness have been more likely to be victims of crimes than to commit crimes (Sadoff, 1978; Steadman, Mulvey, Monahan, Robbin, & Appelbaum, 1998). Teplin et al. (2005) noted that more than one-fourth of individuals with severe mental illness were victims of violent crime in 2004, almost 11 times the general population rate (p. 911). Furthermore, studies found subgroups of individuals with serious mental illness were no more dangerous than the general population (Richard-Duvantoy, Olie & Gourentol, 2009; Torrey, 1994; Warren, Muller, Thomas, Ogloff & Burgess, 2008).

Predicting the level of dangerousness has been an ongoing challenge. The only prediction of dangerousness has been previous acts of violence and even that has not accurately predicted future acts of dangerousness (Appelbaum, 1988; Eisenberg, 2005; Sadoff, 1978; Schopp & Quattrocchi, 1995). As danger has been a vital component of the criteria for civil detainment, the perception of the level of dangerousness in relation to the determination for

www.manaraa.com

mandated treatment has always been a critical issue of debate. According to Pescosolido, Monahon, Link, Stueve, and Kikuzawa (1999), a nationally representative sample of Americans (n=1444), when presented with profiles of individuals that included an element of danger, unanimously endorsed mandated treatment. The question has remained though--how dangerous does one have to be to have his or her *prima facie* right of liberty restricted. This question has become even more important in light of the Commonwealth of Virginia's 2008 civil detainment legislation.

In general, differences in the identification and assessment of dangerousness have been evident between the professional mental health community and the criminal justice system. On the one hand, magistrates judged an individual's level of dangerousness primarily through records of previous acts of violence. Psychiatrists and other mental health professionals, on the other hand, usually judged the individual's level of dangerousness by the severity of his or her mental illness (Poletick, 2002; Roth, 1979; Zemishlany, 2007). Unfortunately, the development of standardized instruments to assess potentially dangerous individuals, although recommended, has never been accomplished (Bauer et al., 2002; Tholen, 2009).

Differences in definition of dangerousness is reflected in the variation of policy from state to state. For example, Nebraska's criterion stated that a mentally ill person must present a "substantial" risk of serious harm to himself and/or to others. On the other hand, Wisconsin has had more general criteria that did not delineate a risk of harm but rather stated that civil detainment was possible if the individual was mentally ill and 'dangerous' (Schopp & Quattrocci, 1995). In Virginia, before the passage of civil detainment laws §37.2-808 and §37.2-809, civil detainment remained prohibited unless an individual with mental illness was in "imminent danger" of hurting self or others. Imminent danger was defined as a danger within 24

www.manaraa.com

hours of when the issue was raised. Not surprisingly, the differences in the understanding the prediction of dangerousness (i.e. a substantial risk of serious harm versus immediate risk of dangerousness allowed a wide margin for variation when interpreting the level of danger as a criterion for civil detainment.

Precursors to civil detainment policy. Stone (1998) observed that public policy often developed in particular ways because policy was subjected to various forces that influenced policymakers. In other words, policy has emerged out of critical incidences. Regarding civil detainment, the security concerns about the community have created a sense of exigency that has been one of the driving forces behind government policy (Stone, 1998). The following examples demonstrated that out of crises, public policy changes occur.

In the state of California, the death of Titiana Tarasoff in 1976 sparked community outrage when it became public knowledge that the treating mental health clinician had known of his client's threat to kill Ms Tarasoff. The clinician informed the police and his employer but due to confidentiality laws at the time, he had not notified the intended victim and/or her family. The ethics surrounding an individual's confidentiality and a potential victim's safety became the focal point for review of policy. Subsequently, legislation was passed and the Tarasoff Law was enacted which stated that the clinician had the duty to warn and breach confidentiality if the individual was determined to be an imminent danger (Ewing, 2005).

In 1999, in the state of New York, a young male who had stopped taking his psychiatric medications, pushed Kendra Webdale into the path of an oncoming train. Her death and other similar events in New York led to extensive publicity and became the focal point for political maneuvering. The outcome of these events led to the establishment of Kendra's Law. This New

www.manaraa.com

York state law allowed courts to order individuals with mental illness who met criteria defined in the legislation to accept treatment as a condition for living in the community (Perlin, 2003).

In the Commonwealth of Virginia on April 16, 2007, Seung-Hui Cho, a student diagnosed with mental illness, gunned down 32 adults on the campus of Virginia Polytechnic Institute and State University before killing himself. One year before the incident, Cho was detained and assessed at Carilion St. Albans Hospital for mandatory psychiatric treatment. However, he was released because he had not met the state's criteria for mandated psychiatric treatment under the existing civil detainment legislation. The language of the civil detainment legislation at that time allowed him to leave the hospital without receiving mental health treatment (Bonnie, 2007; Sluss, 2008).

In Richmond, Virginia, on October 27, 2007, Johnny Hughes stabbed a 72-year-old woman to death on the sidewalk. Hughes reportedly had a long history of involvement with the area Community Services Board (CSB). He had allegedly refused psychiatric medications and had not complied with his treatment plan. The news reported that the CSB had initiated a civil detainment and conducted an evaluation for involuntary commitment, but Hughes had not met the criteria for mandated treatment as defined by legislation at that time (Richmond Times Dispatch, 2008).

The latter two incidents increased concern in Virginia about how to protect the community from potentially dangerous individuals with mental illness, created a sense of urgency to do so, and heightened the public outcry to change to the civil detainment law. The Virginia state legislature passed legislation on July 1, 2008 that increased the specificity of the language of the civil detainment policy to ensure further the safety of the community. Based on the premise of *parens patriae,* the civil detainment legislation was encoded as Emergency

www.manaraa.com

Custody Orders (ECO) §37.2-808 and Temporary Detainment Orders (TDO) §37.2-809. Under the criteria of the new 2008 civil detainment legislation, both Cho and Hughes would have met the criteria for civil detainment.

Prior recommendations for changes in the civil commitment policy that encompassed civil detainment in Commonwealth of Virginia. In 1993, a full study of the civil commitment process was completed and over 32 recommendations made to the General Assembly (JLARC, 1994). Some of these recommendations were to

a. redefine the criteria for civil commitment
b. increase the timeframe for consideration of potential dangerousness
c. increase consistent training of the evaluators
d. record the proceedings during the hearings to ensure protection of the patient's rights
d. utilize the recordings to monitor compliance with the law
e) establish records that tracked the billing of the judges of the proceedings.

Additional recommendations were for the elimination of judges being paid two or three times for the same hearing and for the standardization of the hearing process as some hearings were taking two minutes and others fifteen (JLARC, 1994). These recommendations were not acted upon until the 2008 civil detainment legislation.

Another examination of the Commonwealth's existing mental health statutes surrounding mandated treatment was initiated in October 2006 when the Supreme Court of Virginia established the Commission on Mental Health Law Reform. The Commission was established to conduct a comprehensive examination of Virginia's mental health laws and services. The goals were to also "study ways to use the law more effectively to serve the needs of people with mental illness, while respecting the interests of their families and communities" (Supreme Court

www.manaraa.com

of Virgnia, para.1). After the shootings at Virginia Tech, the Commission on Mental Health Reform commissioned a large-scale qualitative study by a team of faculty and staff at the University of Virginia. This study, referred to as McGravey's study, obtained information about the current system of civil commitment from representative stakeholder groups that involved two hundred and ten (210) individuals (McGravey, 2007). This focus of this study was the civil commitment process. However, elements of civil detainment addressed making these two processes (commitment vs. detainment) difficult to distinguish when interpreting the findings.

Out of this qualitative study, a number of constructs related to the experiences of civil commitment prior to the legislation §37.2-808, §37.2-809, §37.2-817 were uncovered. Consumers (individuals with a mental illness) reported that having a serious mental illness was stigmatizing and resulted in a reduced quality of life. Additionally, consumers reported negative reactions from others, such as being treated like criminals and a sense of being humiliated and degraded. One consistent theme that emerged was poor experiences related to the commitment hearing due to inadequate legal representation (McGravey, 2007).

Requests made by the participants to the Commission were for competent treatment from the medical community, education for all stakeholders regarding the Commonwealth of Virginia's mental health laws. The participants also wanted to be actively involved in treatment at all points in the civil detainment process and afterwards. Opinions were mixed about whether to loosen the criteria for dangerousness or leave it as it was prior to the 2008 legislation. Legislation loosening the criteria for civil detainment as altered and enacted into policy 7 months later.

The incident that occurred at Virginia Tech was devastating and captured the eye of not only the members of the immediate community but also the nation and the world. The media in

www.manaraa.com

the Commonwealth and around the world reported daily on the story and the public watched as the story of the gunman and the victims unfolded on the television and on internet. Televised accounts of that day depicted students jumping out of windows and bloody bodies being carried away. Interviews pointed to a picture of the gunman who had been troubled for years and had not received the needed mental health treatment. In both word and action, government officials from the state responded with a sense of shock, vowing a commitment to safety of the polity through legislative changes.

Changes in Virginia's civil detainment policy. Prior to the legislation §37.2-808, §37.2-809, §37.2-817C being passed in February of 2008, involuntary hospitalization was prohibited unless the individual was in imminent danger (within 24 hours) of hurting him/herself or someone else. Following the shootings at Virginia Tech in April of 2007, the requirement that individuals present an "imminent danger" was altered to a requirement that individuals present a "significant risk" of harm (within 7 to 10 days) (Cohen et al, 2008). The legislation §37.2-808, §37.2-809, §37.2-817 also allowed evidence of previous attempts at harm found in previous treatment records, records of noncompliance with treatment, and reports of witnesses, family members, physicians, or mental health professionals to be introduced at the commitment hearing (Cohen et al., 2008). The revised civil detainment policy included an alteration in the level of dangerousness from "imminent danger to self or others" to "substantial likelihood that .....he or she will cause serious physical harm to himself or others..." (Cohen, et al., 2008, p.7). The language of "substantial likelihood" increased the need to predict the likelihood of dangerous behaviors.

A second change included a shift in timeframes for the determination of danger from "in the imminent future" (24 hours) to "in the near future" (7 to 10 days) (Cohen, Bonnie, &

www.manaraa.com

Monahan, 2008, p.2). This change required individuals to predict the possibility of dangerous behaviors in the future for up to 10 days. This mandate occurred despite the U.S. Supreme Court's opinion that clinicians were unable to predict dangerousness (McDonald & Paitich, 1981; Worrell, 1987; Brooks, 2010).

A third change included the insertion of the language 'unable to care for self' (Cohen, et. al, 2008, p.11). This greater specificity meant that multiple factors such as medication non-compliance or the ability to care for one's basic daily life tasks could be taken into consideration when predicting dangerousness.

A fourth change involved restricting the range of professionals and organizations involved in the civil detainment decision-making process. The change resulted in mandating that any person completing an evaluation of an individual with suspected mental illness for civil detainment be licensed by the State Board of Health Professionals in the Commonwealth of Virginia and be employed by a CSB. This excluded a private clinician from being able to detain an individual with mental illness without the involvement of a CSB employee completing an evaluation (Cohen et al., 2008). In addition, this change mandated that all pre-screeners complete an online training program designed to standardize the method of civil detainment assessments.

A fifth change centered on the evidence allowed during the evaluation. The revised policy permitted evaluators to consider evidence of previous attempts to harm. This evidence obtained from treatment records, records and reports of noncompliance with treatment, and reports of witnesses such as family members, physicians, and mental health professionals was now admissible at the civil detainment hearing (McGravey, 2007; Sluss, 2008; Virginia General Assembly, 2008).

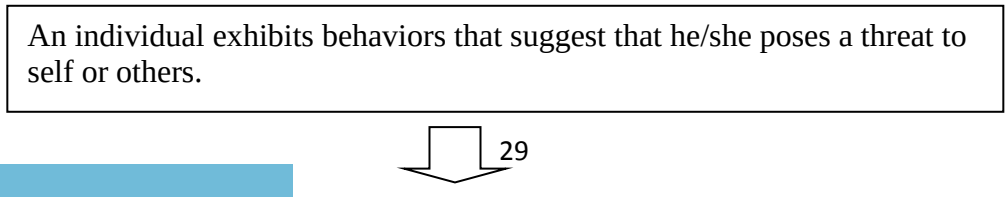
www.manaraa.com

Civil detainment policy process in the Commonwealth of Virginia. The process of civil detainment in Virginia, under the 2008 legislation, involved a number of professionals: psychologists, psychiatrists, lawyers, judges, law enforcement personnel, social workers, nurses, mental health technicians and policy makers. As individuals who had a vested interest in the civil detainment process, these stakeholders entered the civil detainment process through diverse agencies with different goals, variation in professional languages, and a wide range of professional and personal values (Dubois, 2008; Morrissey, Fagan & Cocozza, 2009; Poletiek, 2002; Roth, 1979; Zemishlany, 2007).

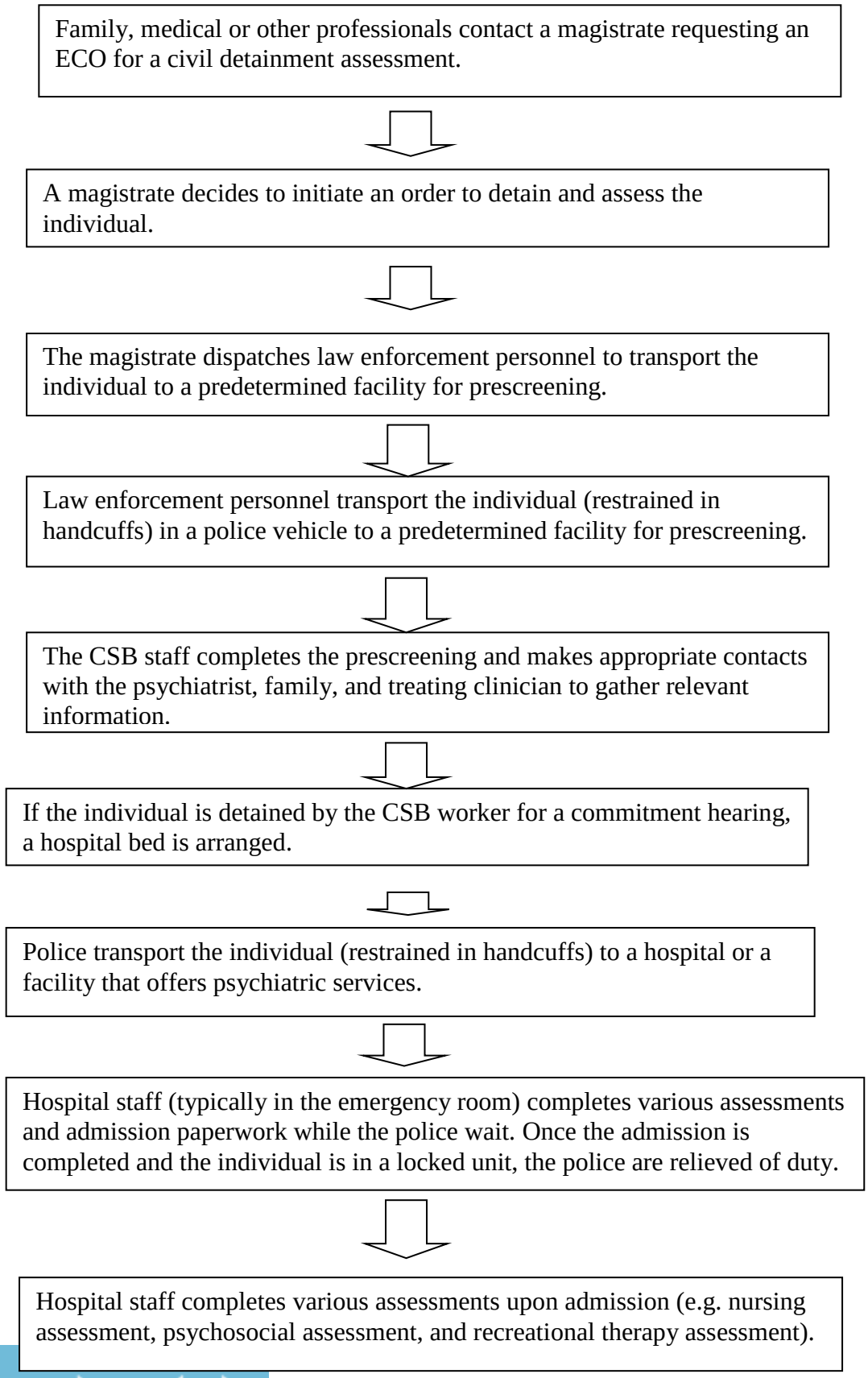
Professionals in the criminal justice systems were expected to execute their duties through the uniform application of the law, assess the individual's level of dangerousness, and protect the individual's right to due process (Brakel, Samuel, &Rock, 1985; LaFond, 1994; Luchins, Cooper, Hanrahan, & Heyrman, 2006; Poletick, 2002; Reid, 2003). The court's primary responsibility was to protect public safety as well as the individual's rights (La Fond, 1994; Roth, 1979; Zemishlany, 2007). On the other hand, the focus of most mental health professionals' involvement related to the detained individual's needs for treatment and overall well-being. These differing perspectives had the potential to complicate the coordination of care, delivery of services, and the process of civil detainment.

Figure 1 illustrated a typical civil detainment process that could occur in response to a request for mandated treatment under the 2008 legislation.

Figure 1: The civil detainment process



www.manaraa.com



www.manaraa.com

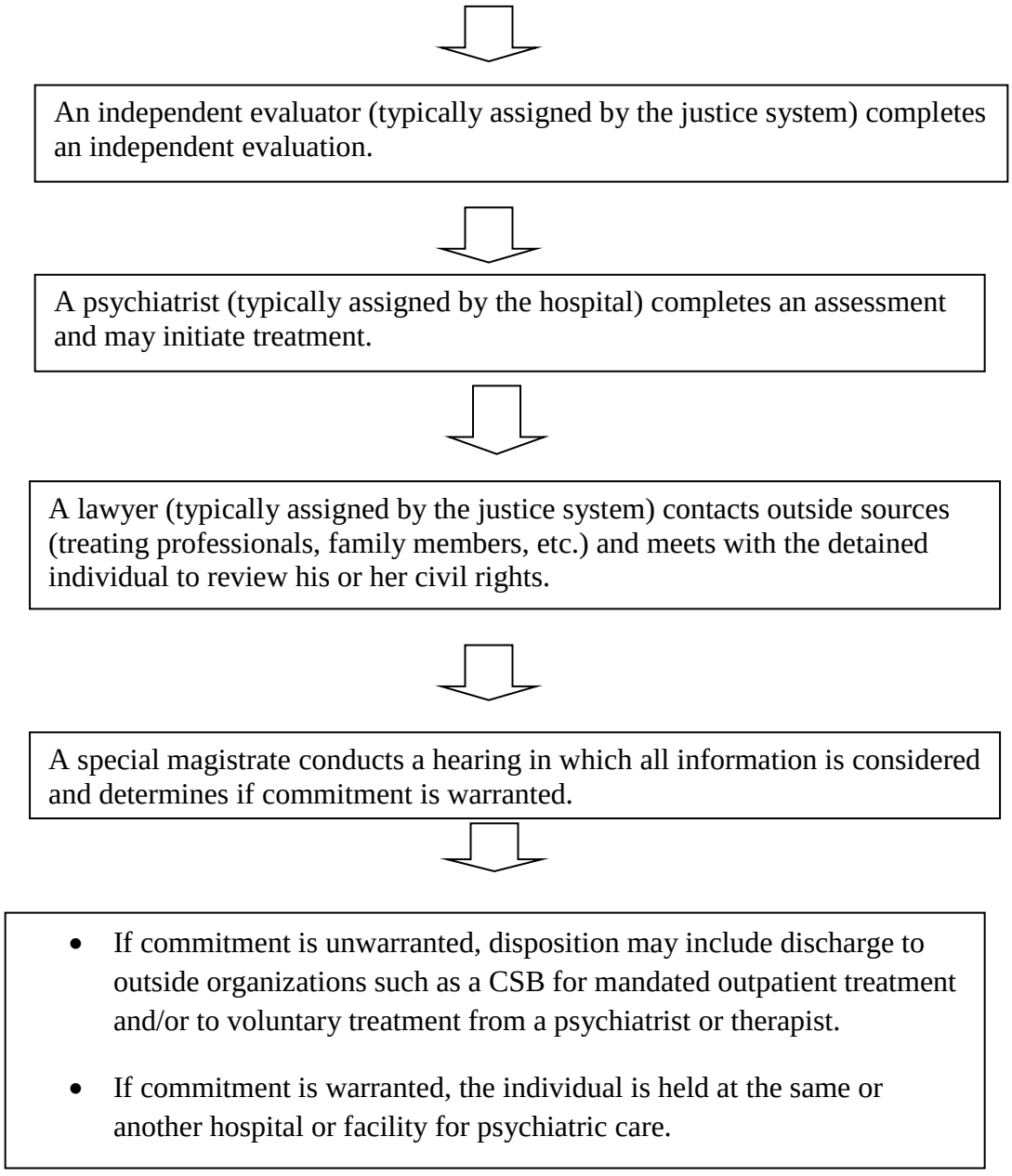


Figure 1 illustrates the steps that are involved in the process of enacting a civil detainment order.

Multiple Perspectives Involved in Civil Detainment

Individuals with mental illness.

www.manaraa.com

The statistical profile of mental illness. According to the National Institute of Mental Health (NIMH) (2008):

- An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year.
- Approximately 20.9 million American adults, or about 9.5 percent of the U.S. population age 18 and older in a given year, have a mood disorder.
- More than 90 percent of people who kill themselves have a diagnosable mental disorder, most commonly a depressive disorder, or a substance abuse disorder.
- Approximately 2.4 million American adults, or about 1.1 percent of the population age 18 and older in a given year, have schizophrenia (NIMH, 2008).

Furthermore, the Center for Disease Control (CDC) (2005) reports that suicide is the 11th most common cause of death. One American kills him or herself every 16.1 minutes and the statistics indicate that suicides by firearms are the most prevalent (52.1%). Additionally, there are 3.8 male deaths by suicide for every female death and every 39 seconds, someone makes an attempt at suicide (CDC, 2005).

The subjective experience of mental illness. A label of mental illness has severe consequences for anyone. Individuals with mental illness have often described their lives as being unstructured, boring, socially disconnected, economically marginalized, or stigmatized by mental illness (Angermeyer, 2003; Schultze & Angermeyer, 2003). Individuals have experienced intermittent discouragement, loss of jobs, loss of homes, loss of social roles, and a sense of engulfment by the illness. The illness has limited individuals' opportunities (Hunter et

www.manaraa.com

al., 2008; Lally, 1989; Roe, 2005) resulting in a loss of roles played within society and the family (Estoff, 1989) and a sense of being "out of step" with life (Armour, Bradshaw, & Roseborough, 2009; Jenkins, 1997).

In many studies on the subjective experience of mental illness, a loss of self was a central theme expressed by individuals with mental illness (Cutting & Dunne, 1989; Estoff, 1989; Lally, 1989; Roe, 2005; Romme & Escher, 1989). Participants described feelings of self-loathing, being overwhelmed, and a desire to hide from the world. They also expressed experiencing a sense of being alone, a need to lean on others, a longing for independence, episodes of depression, fear of stigmatization, shame, and spiritual disconnection (Zolnierk, 2011).

Stigma has been defined as the "co-occurrence of its components–labeling, stereotyping, separation, status loss, and discrimination …and the stigma of mental illness has carried extensive consequences" (Link & Phelan, 2001, p. 363). The effects of stigmatization have led to a sense of hopelessness and constructed attitudinal, structural, and financial barriers in a population of people who were already vulnerable and disenfranchised (NAMI, 2009). Due to the fear of stigmatization, many individuals with mental illness have attempted to hide their illness from coworkers, friends, physicians, and other medical professionals.

Efforts to avoid being labeled have led to increased isolation, misunderstandings, and misdiagnosis (Corrigan & Wassel, 2008; Geller, 2007; Larson & Corrigan, 2008; Link & Phelan, 2001; Lopez, 2002; Morden, Mistler, Weeks, & Bartels, 2009). Not surprisingly, due to negative internalized beliefs about mental illness, individuals with an undiagnosed mental illness have often failed to initiate treatment (Link, 1987; Link et al., 1989; Tally, 2009). Without treatment, symptoms of mental illness worsen and further exacerbate an illness that affects an individual's ability to make sound choices.

www.manaraa.com

Unfortunately, however, after being "outed" as having a mental illness, individuals lost their reputations, privacy, and equality in the medical arena (Corrigan & Watson, 2008). When a diagnosis of a mental illness was known, the individual's judgment was frequently questioned and his or her perceptions and opinions were discounted (Corrigan & Watson, 2008). Long (1998) quoting an individual who experienced a major depressive disorder wrote, "In some cases I became a second class citizen…..It is no wonder that people conceal serious illness, whether cancer, heart disease, or mental illness. Once exposed, these illnesses prove to be unforgettable to others" (para. 4).

Although recent shifts in public opinion have encouraged attitudes of respect and dignity, stigmatization of mental illness has remained a pervasive problem in the 21st century (Appelbaum, 2002; Byrne, 2000). Long wrote that after a diagnosis of mental illness, individuals with mental illness "never walk [ed] with the same dignity again" (Long, 1998, para. 10). Examples of stigmatization can be seen in the media – both in the U.S. and abroad portrayed individuals with mental illness as weak, erratic, impulsive, violent, dangerous, and irresponsible (Levin, 2005). And as discussed above, there have been misperceptions surrounding the dangerousness of individuals with mental illness. One has been the myth that all individuals with mental illness are dangerous, but not all dangerous people are mentally ill (Enis, 1978, Corrigan, Rowan, Green, Lundin, River, Uphoff–Wasowski, & Kubiak, 2002).

The subjective experience of detainment. The literature related to the subjective experience of criminal detainment is primarily anecdotal. Criminal detainment has been typically initiated when an individual is about to commit a crime, is in the act of committing a crime, or has committed a crime. Different forms of criminal detainment have included investigative,

www.manaraa.com

pretrial, preventive, and immigration-related. Criminal detainment has occurred in a number of settings and is often a precursor to arrest.

A number of journalism articles and non-empirical essays described the subjective experience of individuals who were criminally detained (Bryan, 2009; Human Rights Watch, 2010; Moran, 2010; Danes, 2010). These anecdotal findings showed that those who were criminally detained experienced depression, anxiety, a sense of injury to the perception of self, and a feeling of injustice (Bryan, 2009; Farhood, Chaaya, and Saab, 2010; Human Rights Watch, 2010; Moran, 2010; Danes, 2010). Research that examined the consequences of criminal detainment supported the anecdotal assertions that detention was detrimental to detainees – and the mental well-being of the individual worsened in proportion to the length of detainment (Keller, 2003). Many of the adverse effects of detention stemmed from the loss of dignity (JRS-Europe, 2010).

The subjective experience of involuntary treatment through civil commitment. Dignity has been central to the experience of the individual receiving involuntary treatment and research studies have reported that individuals who had been committed for psychiatric treatment experienced treatment without dignity or respect. The loss or preservation of dignity was reported to have a significant impact on the emotional experience of civil commitment (Bay, 2006; Green, 1997; Hallaux, & Bray, 1990a; Katsakou & Priebe, 2007; Kallert, Blockner, & Schutzwoh, 2008; Loue, 2002; McFarland, Faulkner, Bloom, Pescosolido et al., 1999; Pescosolido et al., 2000; Reuland, Schwarzfeld, & Draper, 2009; Sartorius, 2004; Tanay, 2007).

Furthermore, Weinstein (1979) reported that those committed expressed feelings of betrayal from friends or family, fear of re-detainment, and a sense of powerlessness (Weinstein, 1979). Similar experiences were acknowledged by individuals in other studies who reported on

www.manaraa.com

the negative experience of commitment, the use of medications, hospital physicians in the emergency rooms, hospital psychiatrists, and hospital experiences (Edelsohn & Hiday, 1990; Olofsson & Jacobsson, 2001).

Although the use of coercive measures and longer detainment periods has been connected to a detrimental effect on mental health (Kuosmanen, Hätonen, Malkavaara, Kylmä, & Välimäk, 2001; Langle et al., 2003), there is some research that has supported the extension of the detainment periods (Wanchek, 2011) in finding that longer periods of emergency detainment were beneficial for facilitating mental health stabilization. An improvement of symptoms was reported in three-quarters of individuals detained for treatment. In spite of this improvement, individuals with mental illness remained resistant to treatment throughout the hospital stay (Bonovitz & Bonovitz, 1981; Wanchek, 2011).

Civil Commitment in the Commonwealth of Virginia prior to the 2008 legislation. The most extensive study about civil commitment in the Commonwealth of Virginia has been the McGravey study discussed above. The University of Virginia completed this large-scale qualitative study in 2007. As noted above, information was obtained from 210 individuals representing those who had been detained, families, community service board personnel, independent evaluators, special justices, law enforcement offices, emergency room physicians, and admitting psychiatrists. The study established that individuals with serious mental illnesses who were committed for involuntary treatment experienced stigmatization, a reduced quality of life, discrimination, negative reactions of others, a feeling of being treated like criminals, humiliation, and degradation in regards to the commitment hearing (McGravey, 2007). Some of the individuals stated that the system worked well; others stated that the experience was traumatic yet were pleased to be "able to get free care" (p. 43).

www.manaraa.com

The individuals' understanding of mental health laws appeared limited. They were unable to explain the law and the relationship of the law to coercion and mandated treatment. However, individuals had opinions about the use of coercion and mandated treatment; primarily negative. Participants in the study also expressed a desire for a more active role in the decision-making aspect of treatment, wanted competent treatment and believed peer advocates would be beneficial during the process of civil commitment (McGravey, 2007). Additionally, individuals with mental illness, committed, often reported their legal representation was inadequate and the hearings were frightening and confusing. The individuals committed reported difficulty with understanding the procedures during the hearing (McGravey, 2007). Although some of the individuals interviewed stated that the system worked well, many reported involuntary treatment experiences as inadequate, negative, and coerced.

The subjective experience of civil detainment in the Commonwealth of Virginia post 2008 legislation. There is no literature on the subjective experience of the civilly detained individual with mental illness or the identified stakeholders involved in civil detainment following Virginia's 2008 legislation. Thus, to understand the experience of civil detainment post 2008, I examined the phenomenon from the perspective of the individual detained, as each person's experience was unique and contextual. In addition, I believed that understanding the complexity of the experience of civil detainment called for the inclusion of other stakeholders' perspectives such as the families and professionals as civil detainment impacted people beyond the individual detained. For these reasons, I included additional stakeholder groups, such as the family.

Family. A family has been defined as a unit of two or more individuals who identify themselves as a nuclear family, reserving space and time for minimal nuclear unit interaction

www.manaraa.com

(Martinson, 1970). More recently, the definition of a family has expanded to include single parents, biracial couples, blended families, unrelated individuals living cooperatively, and homosexual couples (Crawford, 1999; Kenyon et al., 2003). The U.S. Surgeon General indicated that 1 in 5 Americans suffered from a serious mental illness. Given such a broad definition of family and the prevalence of mental illness, one person's mental illness may affect two or more individuals who were part of the same family. This means that mental illness could affect at least 3 in 5 Americans (USDHHS, 1999).

The burdens of mental illness on the family have been both objective and subjective. Objective burdens have referred to the observable and concrete costs, such as the disruption of daily life and necessary financial expenditures (Jungbauer, Wittmund, Dietrich, & Angermeyer, 2004). The objective burdens on the family include any maneuvering required when acquiring or accessing treatment such as taking days off from work or spending time setting up mental health appointments for the family member with mental illness. Negotiating mental health, medical, welfare, and criminal justice systems have created additional objective burdens on families (Copeland & Heilemann, 2008; McFarland et al., 1990b).

Subjective burdens, discussed frequently in the literature, have included the family's perception of their role related to the needs of the individual with mental illness and the degree to which this role was perceived as burdensome (Jungbauer et al., 2004). These subjective burdens have included the emotional costs to the caregiver and the consequences of discrimination and stigma on finances, occupations, and relationships (Finkleman, 2000; Sartorius, Lett, Lopez-Ibor, Maj & Okasha, 2005).

Families have experienced shame and perceived that other individuals in their life feared contamination from the mental illness. Family members expressed the belief that they should

www.manaraa.com

hide their connection to individuals with mental illness in order to avoid shame (Pescosolido et al., 2000) Families' belief that others perception was that mental illness was due to poor parenting has also created consequences. For instance, if the family internalized that poor parenting or genetics was the cause of the mental illness, family members isolated the individual with mental illness in an effort to minimize the family's "shame" (Ahlstrom, Sharsater, & Danielson, 2010; Angermeyer, Schutze, & Dietrich, 2003; Corker 2001; Hallam, 2007; Mateu & Cuadra, 2007). Isolation placed individuals and families at risk of increased symptomology, exacerbation of stressors, and fear of illness

Some individuals reported a reluctance to have a person with mental illness marry into their family (Pescosolido et al., 2000). Additionally, families perceived individuals with mental illness as causing discord and strain in relationships with nuclear and extended family members. Finally, members of families with mental illness reported lower self-esteem and increased perceptions that others were avoiding them compared to families with no mental illness in the family (Amerongen & Cook, 2010; Hallam, 2007; Larson & Corrigan, 2008; Link, 1982; Phelan, Bromet, & Link, 1998; Thompson & Doll, 1982).

It has been important to consider the impact of the individual with mental illness who is a parent. In a study involving parents diagnosed with a mental illness, other family members expressed the belief that mental illness was "an almost unmanageable situation" and that they (other family members) needed to reconcile themselves to the condition (Ahlstrom et al., 2010). Additional consequences included feelings of worthlessness, hopelessness, and dissatisfaction for both parent and child. Family members such as spouses often needed to assume additional roles to compensate for the individual's mental illness such as taking second jobs, calling medical offices, and assuming full parental control.

www.manaraa.com

A concern about the dangers posed by a family member who had a mental illness has been an additional stressor – and these fears have not been unfounded. Studies found family members or acquaintances of mentally ill persons were more likely to be harmed and experienced a greater propensity for violence from their family member with mental illness than were strangers (Arboleda-Florez, 1998; Copeland, 2007; Eronen et al., 1998). If civil detainment and subsequent hospitalization became necessary, families experienced additional stress and burdens financially. Subsequently, these stressors increased family members' frustration and anger toward the individual with the mental illness. Copeland & Heilemann (2008) found that mothers of adult children with mental illness experienced subjective burdens when attempting to gain treatment for their adult children in that they experienced periods of chaos and fear as well as a sense of responsibility for the consequences of committing their children to mandated treatment.

Although there have not been studies about civil detainment from the family's perspective, McFarlan et al. (1990b) and Kallert, (2008) examined the effects of civil commitment on families. Their findings concluded that the use of involuntary treatment made it more likely that the family felt excluded from treatment (McFarland et al., 1990b; Kallert, 2008). If a family member forced an individual to seek treatment, the individual detained sometimes interpreted the forced treatment as a genuine demonstration by the family of care and respect for an individual's human dignity and at other times as a measure denying autonomy and limiting dignity (Pinsen & VanDelden, 2009; Wyatt, 2001).

In McGravey's study, stakeholder families reported that Virginia's mental health system was in a crisis. For instance, civil commitment hearings occurred in makeshift rooms near psychiatric units that served as courtrooms and conditions were inconsistent regarding the review

www.manaraa.com

of civil rights and cross-examination of individuals subjected to civil commitment. The families expressed frustration about the difficulties of accessing treatment. Specifically, they reported difficulty in finding beds or an adequate continuum of services necessary for quality treatment, in securing funding for treatment, with managing the inconsistencies between agencies, and minimizing the complications in relation to transportation of the individual detained to the designated facilities (McGravey, 2007).

The mental health professionals. The relationship between the mental health profession and mental illness has been full of struggles associated with conflicting beliefs about the illness (Sharfstein, 2000). According to Brooks (2012), psychiatrists' views and beliefs about civil detainment or civil commitment have not been examined nationally in the last 25 years.

The role of the psychiatrist in the civil detainment process has evolved through the years. Initially, psychiatrists were the sole determiners of civil detainment. Before the 1970s, individuals faced confinement based on the diagnosis of one psychiatrist. Through the involvement of civil libertarians in the mid-seventies, the process of civil detainment developed into one that required the evaluation by two psychiatrists.

In the late 20th century, the civil rights of individuals with mental illness were further protected by the inclusion of a mandatory independent psychiatric evaluator that was employed by the judicial system (Schulberg & Killilea, 1982; Applebaum, 2006). An additional independent evaluation by a mental health professional employed by the CSB became yet another step in the process of detainment to protect an individual's right to liberty but the standardization of their involvement was not clearly defined. Through the years, the diversity of mental health professionals involved in the civil detainment process increased and the

www.manaraa.com

psychiatrist was no longer the sole expert. Instead, the initial steps of the civil detainment process expanded to include social workers and other mental health professionals.

In Virginia, the role of the mental health professionals involved in civil detainment expanded after the 2008 legislation when CSBs became the gatekeepers of civil detainment. The legislation assigned responsibility to the CSBs to make the initial determination for mandated treatment and to participate in the civil commitment hearings. All professionals who were eligible to participate in subsequent determinations of civil detainment criteria (such as CSBs, legal professionals, magistrates, and law enforcement officials) were also required to complete standardized training developed by the Department of Behavioral Health and Developmental Services (DBHDS) that addressed the nuances in the language of the 2008 policy (DBHDS, 2010).

According to the literature, a number of factors have affected the mental health professionals' decision-making process. These factors influenced how and when civil detainment for a civil commitment was initiated and ultimately increased the chances of inconsistencies in applying criteria. Availability of hospital beds, clinicians' tendency to detain patients, the interpretation of the criteria of dangerousness, the availability of funding, the experience of the professional, and the ethical benefits of commitment were all found to be additional considerations for making decisions about civil detainment (Alexius, Ajuefors, Berg, & Aberg-Wistedt, 2002; Engleman, Jobes, Berman, & Langbeing, 1998; Monahan et al., 1995).

Fears of liability in the wake of events such as the shootings at Virginia Tech may have lead clinicians to err on the side of caution when initiating a civil detention. Current legislation (i.e. §37. 2-808 and §37. 2-809) may have encouraged professionals to favor security or preventative detainment. The psychiatric use of preventative detainment, in the past, led to

www.manaraa.com

issues pertaining to its constitutionality. To protect an individual's constitutional rights, the legislation prohibited confining individuals who were dangerous unless they had a mental illness (Enis, 1978; Large et al., 2007; McDonald & Paitich, 1981).

Clinicians with a higher level of threshold for the potential for danger due to their level of expertise and increased experience in the field of mental health were assessing the detained individual differently than the newer mental health clinicians (Poletiek, 2002). Known as expertise bias, this provided an explanation for inconsistencies in the determination of whether mandated treatment in the form of civil detainment was necessary. An increased tolerance for potential danger resulted in more experienced clinicians' applying less stringent adherence to the letter of the law. Lack of uniformity in civil detainment determinations posed risks to individuals with mental illness since clinicians have not evaluated each individual using the same criteria. Furthermore, Poletiek (2002) asserted that expertise bias may negatively affect the individual's right to liberty, sense of dignity, and autonomy. Expertise bias has not been studied as a factor in the application of the Commonwealth of Virginia's 2008 legislation.

In sum, during the civil detainment process, detained individuals encountered psychiatric nurses, mental health social workers, psychologists, psychiatric technicians, and psychiatrists. All of these professionals played a role in assessing and recommending services related to mandatory treatment, prescribing medications to alleviate symptoms, and verifying the probability of violence to self or others. Studies have shown that differences in levels of training of these various disciplines resulted in inconsistencies in civil commitment assessments and treatment (Brooks, 2012; Poletick, 2002; Roth, 1979; Zemishlany, 2007).

The first responders-the criminal justice system. The Virginia criminal justice system's mission is "to improve and promote public safety in the Commonwealth" (Virginia

www.manaraa.com

Department of Criminal Justice System, ND, p. 1). The criminal justice system is involved with civil detainment through several law enforcement branches comprised of magistrates, attorneys, independent evaluators and law enforcement agencies. Each criminal justice professional and organization plays a different role in civil detainment according to the different purposes and missions of their respective profession or organization.

Law enforcement personnel, usually police, have been the first responders in a crisis involving individuals with mental illness. In a moment of crisis, the police have had several options, including doing nothing. If they deemed action necessary, police officers had the capacity to resolve a situation informally, arrest the individual, or seek other formal resolutions such as psychiatric hospitalization (Watson, Morabito, Draine, & Ottati, 2008). Sometimes crisis encounters resulted in injury for possibly both the police officers and individuals with mental illness (Cordner, 2006). The potential for injuries at times resulted in the decisions being made quickly. Cordner (2006) asserts that with sufficient time, police officers have the potential to resolve situations peacefully.

Law enforcement officials have also been responsible for the decision to send individuals with mental illness either into the jail system or the mental health system. This mandate to act placed the officers in a position of power. The officers decided whether an individual was subject to the criminal justice system or the mental health system – or should remain at liberty. Unfortunately, barriers to treatment (such as lack of psychiatric bed availability) left the individual with mental illness at higher risk of facing detention in the criminal system (Sharstein & Dickerson, 2009).

The literature review found no national studies that examined the perspective or experiences of the law enforcement personnel regarding civil detainment. The bulk of the

www.manaraa.com

research focused on the procedures that police utilized during the training that was available and other logistics that affected the detainment process for law enforcement personnel.

McGravey's (2007) study found, in the Commonwealth of Virginia, that police expressed a sense of 'being torn' to fulfill the requirements of the civil detainment order and to fulfill the requirements of an officer on duty in the community. Frustration was noted in the long waits that law enforcement officials experienced while waiting on hospital beds and hospital staff to assume responsibility for the individual detained.

The judicial professionals. The attorney's role has been to represent the individual in a civil commitment hearing and to protect the legal interests of the client versus promoting the mental health of the individual (Chen 2010; La Fond 1994; Patch & Arrigo, 1999; Watson et al., 2008). However, over the years, this involvement has expanded so that lawyers may now play the role of both advocate and judge. The literature review found no studies that examined the perspective or experience of the lawyers related to the civil detainment process.

Other judicial system professionals involved in the civil detainment process have been magistrates, judges, and assigned independent evaluators. The role of the magistrate has been to issue civil detainment orders if he or she determined that the information provided as evidence for a civil detainment order was credible. The judge's role has been to listen to all evidence and determine if the individual detained was remanded for ongoing mandated treatment. The independent evaluator, typically a licensed psychologist considered an agent of the judicial system, was to evaluate the individual after the detained individual was admitted to the psychiatric facility and prior to the civil detainment hearing. There was no recent literature on the subjective perspectives of the criminal justice professional as it related to civil detainment.

www.manaraa.com

Curtailing an individual's liberty has required evidence of a clear and convincing need for civil detainment. There had to be a preponderance of evidence and the burden of proof was less than beyond reasonable doubt (Henwood, 2008). However, several studies have found that individuals in legal systems have failed to consistently enforce these standards (Appelbaum, 1988, RAND, 2010; Brooks, 2012).

Models of treatment.

Proponents of different treatment models have offered yet another nuance to civil detainment. A treatment model is a framework that has described, directed and accounted for the behavior or care offered and represented a system of beliefs and theories related to the treatment of an illness. Recently, stakeholders have ascribed to two conflicting models of treatment, the medical model and the recovery model. Both models of treatment have the capability to influence the decision making process between detainment and autonomy for the individual with mental illness.

Medical model. In the field of mental health, the term "medical model" has meant, "focusing on faulty mental mechanisms as a disease or pathology" (Freeth, 2007, p. 3). The medical model of care within the psychiatric field originated from Laing (1971). Laing did not support the diagnosis of mental illness based solely on the behavior of the individual with mental illness. Rather, he believed that symptoms of mental illness were treatable from a scientific perspective, so subsequently, he introduced the medical model of care in the field of psychiatry. Laing (1971) strove to have psychiatry respected within the medical community. He asserted that mental illness was a medical illness to be care for systematically-not by conjecture but rather by standardized medical procedures (Beveridge, 1998).

www.manaraa.com

The medical model is considered a reductionist model of care. The model, founded on pathologizing symptoms of mental illness, treats the human body as a complex mechanism. Professionals advocating for this model of care claim that it is possible to have a value-neutral classification scheme in making determinations of mental illness (Perring, 2010). Physicians who subscribe to this model utilize a standardized set of procedures in a prescriptive manner throughout the processes of assessment, diagnosis, and treatment. These three processes represent a particular way of explaining problems or pathologies treated (Sadler, 2005).

The medical model remains the standard of practice for the treatment of mental illness in the 21st century (Appelbaum, 2006). In this model, deference is given to the psychiatrist as the medical doctor. As a result, the psychiatrist's role is often the ultimate authority in the civil commitment process.

Recovery model. Although a singular definition of recovery remains elusive, Ralph and Corrigan, (2005) attempt to define recovery as learning to live well in spite of difficulties of illness. The model identifies recovery as a demonstration of continual growth, increased control over one's life, and highly individualized, nonlinear, ongoing treatment. This model also views relapse as a process rather than a failure (Corrigan, 2002; Corrigan & Lundin, 2001; Jacobson & Greenleyk, 2001; NASW, 2000b; Ralph & Corrigan, 2005). In contrast to the medical model, the recovery model situates the individual as an active participant in his or her personal recovery and the expert on his or her own experience.

The recovery model, as defined by NASW (2000b), is "a treatment concept" that involves an environment of service designed to ensure that individuals have paramount control over decisions concerning their care. This model proposes that a health care provider's role is not to make decisions for the client. Instead, the provider is to advocate for and educate

www.manaraa.com

individuals with a mental illness about the possible outcomes of their decisions as it relates to their mental illness. Consequently, providers using the recovery model integrate treatments provided by the medical professionals, mental health professionals (medications and traditional therapies) and community organization programs (peer run support groups and peer run drop-in centers).

Critical factors in recovery include a sense of independence, a belief that someone is "in it with them" (Bradshaw et al., 2006, p.128), and a feeling of hopefulness in relation to medications. Validation catharsis, telling their story, and an awareness of skills gained through the role of consumer educator have also surfaced as important factors in recovery (Borg & Kristiansen, 2004; Kowlesser & Corbett, 2008; Pitt & Kilbride, 2006).

The recovery model incorporates interconnections among internal resources such as hope, empowerment, and healing. These connections are linked to external resources such as the appropriate application of human rights, a positive culture of healing, and recovery-oriented services that promote the individual as the expert (Jacobson & Greenley, 2001; NASW, 2000a).

Because the recovery model supports the belief that individuals have the right to determine their treatment, the goals of the recovery model conflicts with the process of civil detainment at times. Conflicts over models of treatment produce rifts among advocates of the medical model, and advocates of the recovery model, which often include those in the community (Jacobson & Greenley, 2001). Additionally, the recovery model's advocates continue to debate how, when, and to what extent mental illness limits a person's capacity to make sound choices and necessitate civil detainment (Jacobson & Greenley, 2001; Pouncey & Lukens, 2010).

www.manaraa.com

Social Constructivist Theory

Social constructivist theory argues that the creation of knowledge happens in social groups, based on the interactions within different members of a group and their mutual learning from one another (Gredler, 1997; Kim, 2006; Vygotsky, 1978). Social constructivism emphasizes the importance of culture and context in understanding experiences.

This process is an active, building process during which people construct their own subjective representations of objective reality. Prior knowledge linked to new information creates mental representations that are subjective, unique and constructed through the interactions with others and the environment. This uniqueness of constructs supports the belief that multiple truths exist, are individual and are contextual.

According to Guba and Lincoln (1989), the basic ontological assumption of constructivism is relativism. However, there is no objective truth with relativism. This theory emphasizes the importance of culture and context in understanding any experience such as civil detainment. One premise of social constructivism has been that individuals socially and culturally construct knowledge. This theory suggests that stakeholders in the process of civil detainment create shared meanings, resulting in the inter-subjectivity of the experience. Epistemologically, the stakeholders' sharing of their reality of the civil detainment experience creates a dialectical process, one that utilizes questioning and answering as a means to resolve multiple perspectives and paradigms. For this reason social constructivist theory was particularly well suited to examine the phenomenon of civil detainment.

Social constructivism also acknowledges contextual elements. In civil detainment, these contextual elements include the existing legislation at the time of the civil detainment, the severity of the mental illness, the geographical location of the civil detainment, and the beliefs of

www.manaraa.com

the individuals involved. The contextual elements includes constructs such as recovery, dangerousness, and dignity that intertwine to create the experience of civil detainment.

In the dialectical process, multiple perspectives on reality prevent an oversimplification of the complexities in a situation such as civil detainment. The inter-subjectivity of the individuals involved in a constructivist inquiry facilitates the enhancement and the development of personal meanings about civil detainment (Gredler, 1997; Kim, 2001). Thus, in this study, the experience of civil detainment was best understood and explored through knowledge that was constructed and actualized by the individuals involved (Ackerman, 2009; Brown, Collins & Duguid, 1989; Kim, 2001).

In order to understand the experience of civil detainment fully, the inquiry required a theory and a research methodology that valued the contextual nature of the phenomenon, the multiple perspectives of the participants, and the phenomenon's complexity. The research methodology necessitated the use of a constructivist inquiry with its ethnographic methods within a framework paradigmatically dissimilar from conventional research (Rodwell, 1998). Altogether, there was not one truth about civil detainment.

The Research Question

What are the multiple perspectives of the lived experience of civil detainment subsequent to the 2008legislation?

This literature review clearly suggests that multiple issues have the potential to impact the individuals involved in the experience of civil detainment. However, there is no research on the lived experience of civil detainment subsequent to the 2008 civil detainment legislation in the Commonwealth of Virginia.

www.manaraa.com

The goal of this inquiry is to develop a deeper understanding of the phenomenon of the experience of civil detainment in order to prompt future policies to consider the various perspectives of the stakeholders who participated in this inquiry.

The Conceptual Framework

Based on the review of the literature, I organized a conceptual framework to allow others to understand the relationships among the primary constructs of social contract theory, civil detainment policy, and multiple perspectives of civil detainment. These constructs helped to guide and bound the inquiry as a whole. The constructs led to the working hypotheses and the foreshadowed questions presented in Table 2. This framework supports the basis for exploring the wide range of experiences of civil detainment found in this dissertation.

Table 2: The conceptual map

Framework		
Constructs	**Working Hypotheses**	**Foreshadowed Questions**
• **Social Contract Theory** • **Criteria for Civil Detainment** • **Civil Detainment Legislation**	Different stakeholders will have multiple understandings of civil detainment and varying perspectives on the purpose of the new legislation.	**Would you share your feelings, thoughts, and understanding of the civil detainment law?**
• **Social Constructivist Theory** • **Civil Detainment Legislation** • **Diverse Values and Perspectives**	The experiences of civil detainment will vary reflecting the inconsistencies of the "policy-in-experience".	**Would you share your experiences with civil detainment?**
• **Criteria for Civil Detainment** • **Diverse Values and Perspectives** • **Civil Detainment**	The meaning of civil detainment will depend on the stakeholders' perspective on recovery, dangerousness, and dignity	**Would you share how the experience of civil detainment has affected your perception of yourself or individuals with mental illnesses?**

www.manaraa.com

Legislation • **Social Constructivist Theory**	contextual to the experience of detainment.

Table 2 demonstrates the linkage between the constructs examined, the working hypotheses and the foreshadowed questions.

www.manaraa.com

Chapter Three: Methodology

The purpose of this inquiry was not to discover an absolute truth about civil detainment because I recognized the concept of multiple realities. This inquiry was designed to explore the phenomenon from multiple points of view and thereby deepen the understanding of the experience of civil detainment. My goal was to capture diverse understandings about the multiple perspectives that emerged when the civil detainment policy was experienced.

Qualitative methodology seemed to be the most appropriate research approach for several reasons. First, approaches used in social work research should be consistent with values that support and direct social work practice (O'Connor & Neill, 2009). As promotion of dignity was one primary value of social work practice (NASW, 1999), use of this methodology advances emancipation. It offers individuals involved in the civil detainment the opportunity to share personal experiences that may not have been shared and advancing his or her sense of dignity (Chochinov, Hack, Kristianson, McClement, & Harlos, 2005),

Secondly, qualitative methods addressed the person-in-the-environment, a grounding principle of the social work profession, as it placed the individual's experience as the foci of the study, studied the individual in his or her natural setting, and included the contextual aspects of the phenomenon. The paucity of research about civil detainment also called for qualitative methods as qualitative research techniques are useful for gathering and analyzing exploratory data on phenomenon not previously explored (Berkowitz and Inui, 1998). Such methodology allowed me to develop an understanding of the experience of civil detainment post the 2008 legislation which had not been researched. Qualitative methods also enabled me to identify variables that may later be tested quantitatively (Strauss & Corbin, 1990).

www.manaraa.com

This chapter provides an overview of the interpretive paradigm and constructivist methodology. It also examines the fit, focus, and feasibility of the inquiry. In addition, this chapter details the specifics of my interactions with participants, my collection of raw data, and the creation of the case study report. It also delineates methods used to ensure the rigor and accuracy of my inquiry, including the establishment of trustworthiness and authenticity through an outside audit.

My study focused on the citizens of the Commonwealth of Virginia involved with civil detainment subsequent to the 2008 legislation. I posed a research question that was designed to elicit multiple perspectives and multiple truths: "Subsequent to the enactment of the 2008 Virginia legislation §37.2-808 (ECO) and §37.2-809 (TDO), what are the multiple perspectives of the lived experience of civil detainment?"

Determining the Appropriate Paradigm, Theory, and Method

In designing my inquiry, I knew that a research paradigm was critical and I needed "a basic set of beliefs that guide action" (Denzin & Lincoln, 2000, p. 157). I chose to use an interpretivist paradigm. Proponents of interpretivist paradigms have argued in favor of the existence of multiple realities that differ across time, places, and people (Burrell & Morgan, 1979).

Researchers using an interpretive paradigm share several beliefs about the nature of knowledge and reality. First, reality as we know it has been constructed intersubjectively through meanings and understandings that people develop among themselves socially and experientially. Second, we have not been able to separate ourselves from what we know. Finally, reality cannot be separated from our knowledge and understanding of it (i.e., that there is

www.manaraa.com

no separation of subject and object). These values were inherent in all phases of the research process for this inquiry (Rodwell, 1988).

Constructivism

The constructivist approach "emphasized human agency and reality socially and psychologically constructed" (Rodwell, 1998, p. 19). Given the multiple perspectives within the experience of civil detainment, there were many different ways to understand and interpret the stages of the civil detainment experience post 2008. Therefore, a constructivist approach was well suited to this kind of inquiry. Such an approach honored the interplay between the individuals involved in civil detainment and the social and political atmosphere within which civil detainment occurred in of the Commonwealth of Virginia after the enactment of the civil detainment legislation, §37.2-808 and §37.2-809.

Earlier I established that the inquiry calls for an interpretivist paradigm. Constructivism landed squarely within the interpretivist paradigm due to shared beliefs. Rodwell (1998) stated that constructivism was based on the following beliefs:

- There were multiple constructed realities that are constructed by the participants
- There was no subject-object dualism
- The goal of the inquiry was to understand the phenomena at the subjective level
- There were no causal linkages as there are multiple influences that share the phenomena
- The inquiry was value bound (p. 17).

Constructivism was also well suited for me as I shared similar ontological and epistemological beliefs.

www.manaraa.com

I believe in multiple realities that are unique to each individual. My belief is that realities are constructed through a process of interacting with the environment and other human beings.

Much of the information in this inquiry was gathered from interviews, which I analyzed through constant comparison of the text. Individual interviews were particularly valuable tools for this kind of research since my goal was to understand multiple perspectives on civil detainment from an individual perspective; did not seek universal truth.

Instead, I sought a deeper understanding of the detainment experience within the context of the current legislation. Throughout the inquiry, I considered multiple truths and differing realities, not only those from the participants' perspective but also from my own journey. I hoped that my insights and inquiries would be of practical use to policymakers and social work practitioners, psychiatrists, emergency room nurses, and law enforcement personnel.

Constructivist Methods

Focus. According to Rodwell (1998), pure research defines the depth and scope of the phenomenon focusing on understanding (Rodwell, 1998, p.38). The target of this inquiry was on understanding the phenomenon of civil detainment for knowledge sake. Understanding the emphasis of this research helped me to determine the limits for the inquiry process and the criteria for what data needed to be included or excluded (Rodwell, 1998).

Policy-in-experience was a term used to describe citizens' actual lived experience of policies implemented by the government.

. As I explored the "policy-in-experience" (Guba, 1985) pertaining to civil detainment, it became clear from the literature review that civil detainment affected five groups of individuals. These individual groups were later redefined through the process of the constructivist inquiry and are as follows::

www.manaraa.com

- The individual with mental illness
- The families of individuals with mental illness
- Mental health professionals who initiated or become involved in civil detainment
- First responders, such as police officers, rescue squads, CSB evaluators, ER personnel
- The professionals in the judicial system

Each group of individuals had a stake in how the Commonwealth of Virginia implemented the legislation and therefore each group became a stakeholder group.

This inquiry strove to understand the experience of civil detainment from the multiple perspectives of individuals involved in the process: detainees, law enforcement officials, and others involved in civil detainment. It focused specifically on individuals' experience as it related to a specific piece of legislation in Virginia -- the civil detainment legislation, §37.2-808 and §37.2-809 -- which provided the boundaries of the inquiry and the criteria for inclusion/exclusion of data and participants (Rodwell, 1998). I selected an initial group of individuals to participate, and they guided the identification of additional stakeholder groups. These additional stakeholder groups expanded the understandings of the context and decisions involved in civil detainment.

The literature review suggested that the experience of civil detainment reflected values pertaining to recovery, dangerousness, and dignity, within a specific policy context. This information assisted the formulation of the working hypotheses and the foreshadowed questions. These values were expected to influence the implementation, shape the experience of the participants and be evident in the stakeholders' beliefs about the policy (Rodwell, 1998). The foreshadowed questions were developed to explore the values and meaning of the civil

www.manaraa.com

detainment legislation, the multiple perspectives within the experience of civil detainment, and the meaning of civil detainment within the context and boundaries of the phenomenon. The construction of the conceptual model, the case story and the lessons learned (what I came to know) that emerged from this inquiry involved the individuals experiencing the policy, the perception of their experiences, the impact of their experiences, and the collaborative reconstruction of data into the final product.

Fit. For any constructivist inquiry, the assumptions that undergirded the inquiry has to be congruent or fit with the underpinning assumptions of constructivist methodology. The assumptions of a constructivist inquiry must include the following:

a. Multiple realities were studied
b. The phenomenon was dependent on the context
c. The issue to be studied was complex and does not have a single cause
d. Objectivity was not at issue
e. Values were central to the problem (Rodwell, 1998, p. 40-41).

The subject of my inquiry met all of these parameters. Civil detainment was experienced by all individuals involved through the process. Second, the initiation of a civil detainment was dependent on the contextual aspects of the experience such as time of the incident, the location within Virginia, the multiple perspectives involved, available resources, and the severity of the mental illness. Third, given that civil detainment was contextual, there was no one cause and the overall experience was complex. Finally, values were pivotal to the initiation and execution of a civil detainment order such as beliefs about mental illness, liberty, autonomy, and dignity. My research question about civil detainment took into account these multiple contexts. Each experience of civil detainment was unique to the individual.

www.manaraa.com

According to literature reviewed, the rationale for, initiation of, and experience of civil detainment were complex occurrences that lacked causal explanations. Therefore, the results of the inquiry could only be understood within the context of the study and were not intended to be generalizable to individuals with different circumstances or to offer causal explanations. Rather the inquiry concentrated on deepening the understanding of the phenomenon of civil detainment.

Through a hermeneutic process that encouraged a variety of views to be considered, the inquiry intentionally encouraged the empowerment of the participants (Rodwell, 1998). I recognized this empowerment process through verbal statements, which indicated they learned from the process of sharing their story; felt validated; and learned from the process of sharing and hearing other perspectives. I noted participants expressed hope that changes to the experience of civil detainment would be possible due to their involvement with this inquiry.

Participants seemed to gain a greater understanding of the civil detainment process when questions encouraged them to examine relationships among the individuals with mental illness, their families, and law enforcement and mental health professionals. The inquiry also examined relationships between and within organizations, among different policies in effect, and within values held by the participants involved with the inquiry. Through the process of sharing of experiences, the participants became co-constructors of the project and reached a deeper understanding of the phenomenon (Rodwell, 1998). This deeper understanding included an examination of the values central to the experience of civil detainment. This examination of values was necessary as they were tightly interwoven and could not be separated in an attempt to understand the phenomenon of civil detainment. The values of both the participants and the inquirer were honored and included in the inquiry.

www.manaraa.com

Feasibility. Determining feasibility meant examining if the inquiry was possible. My position in the clinical field of mental health afforded me relationships to gatekeepers who granted me access to participants and any additional information needed for my inquiry. This access to participants enabled me to obtain maximum variation of subjects, otherwise known as heterogeneity, through purposeful sampling (Cohen, 2006). A thick description has been defined as a full description of the phenomenon that is inclusive of all aspects of the context for meaning making (Rodwell, 1998, p. 181). Because of my ability to gather both participants and nonhuman data sources (i.e. the legislative policy, news articles, etc), I was able to develop a thick description of the civil detainment phenomenon.

To fulfill the feasibility requirements of a constructivist inquiry, it was necessary to get a commitment from all individuals to enter into the inquiry from a position of integrity. It was important that participants would be without fear of reprisals for opinions and beliefs that might be controversial (Rodwell, 1998). In addition to an honest presentation of the multiple perspectives, the inquiry required the participants' time and energy to ensure the co-construction was thorough and extensive.

During this inquiry, all participants were eager and willing to engage in the process. Some participants were so eager to communicate their experiences with civil detainment that interviews originally scheduled to be 60 minutes long were extended by the participants up to 180 minutes. Throughout the nine months of data collection and regular member checking, participants were accessible and remained engaged.

Constructivist Design

The inquiry had a planned structure consisting of three phases. Although the outcomes within each phase could not be fully known until the final phase was completed, the three phases

www.manaraa.com

allowed for the identification of central queries, the determination of meanings, and the assurance of rigor (Lincoln & Guba, 1989). The phases were guided by the stakeholders' input about their experiences, concerns, and values (Rodwell, 1989). The phases are outlined below.

Phase I-Orientation and Overview

The phenomenon was inspired by my prior knowledge based on personal and professional experiences, review of the literature, and my curiosity about occurrences that I, as a mental health professional, had witnessed or participated in. My prior knowledge helped me develop questions that provided an entry in the investigation. As the inquiry unfolded, the questions became more sophisticated as pieces of the "puzzle" about the experience of civil detainment emerged.

As part of my initial exploration, I completed ethnographic activities. I examined previous inquiries about the phenomenon, reviewed events in the Commonwealth, and studied new legislation. These activities aided in the determination of the feasibility of the project. As part of this phase, I also identified important stakeholders and gatekeepers, worked on gaining entry, and negotiated the gatekeepers' consent. During this phase of the inquiry, I developed the reflexive journal that captured my emotions, values, and reactions as they related to the development of the inquiry. This journal was maintained through the entire study and it was continued past the completion of the audit. Therefore, the process of understanding continued long after the completion of the initial data collection and subsequent verification.

During this phase, I also developed a methodological journal to record all methodological changes considered or completed as the inquiry's design emerged. At times, my wonderings, concerns, or feelings documented in the reflexive journal emerged as decisions about the process

www.manaraa.com

of the investigation; these decisions were then recorded in the methodological journal (Rodwell, 1998).

Entry. A constructivist inquiry required that I enter the inquiry in the natural setting of the phenomenon (Rodwell 1998). Prior knowledge was necessary for me to understand what comprised a natural setting for the questions. This was accomplished though literature review, prior ethnography, and my own experience with and knowledge of civil detainment.

Utilizing the natural setting was critical since the reality of individuals' experiences with civil detainment could not be understood in isolation. For this reason, I completed the interviews of all participants within the context of the phenomenon. Natural settings included the Commonwealth of Virginia and the participants' homes, offices, and community locations. Such locations gave me the opportunity to interact with the setting itself as well as the individuals allowing me an opportunity to understand all facets of their reality. In those settings, I was also able to help with the process of reconstruction that became meaningful to the individuals.

Utilizing my own understanding of the context of civil detainment and prior ethnography, my working hypotheses emerged. As seen through the conceptual framework (discussed in Chapter 2 and in Appendix I), constructs that became clearer in my thinking through the use of my reflexive journal, prior ethnography and a review of the literature developed the working hypotheses that guided the data collection and analysis. The working hypotheses were as follows:

- Different stakeholders will have multiple understandings of civil detainment and varying perspectives on the purpose of the new legislation.
- The experiences of civil detainment will vary greatly, reflecting the inconsistencies of the "policy–in-experience".

www.manaraa.com

- The meaning of civil detainment will depend on the stakeholders' perspective on recovery, dangerousness, and dignity contextual to the experience of detainment.

Research design. The design emerged during the course of the inquiry, as I could not understand the complexity and completeness of the multiple realities prior to their manifestation. These complexities included not only the participants' experiences but also evolving legislation. Each new discovery during the inquiry shaped the design and process (Burrell & Morgan, 1979). The flexibility of a constructivist inquiry allowed for the inclusion of the multiple realities as part of the investigation and provided a framework to permit the influence of those realities on the emergent design.

I entered into this inquiry with problem-determined boundaries, my own understanding of the phenomenon, awareness of the values at play, the context of the phenomenon and the initial identification of the stakeholders. In a parallel process, I entered into this research design with the awareness that my interactions with the participants and encounters with multiple realities both influenced and altered my understanding of civil detainment.

An emergent design required that I utilize purposive sampling to achieve maximum variation of multiple perspectives (Rodwell, 1989). My goal was to understand the phenomenon as it related to a particular set of cases versus generalizing to a larger population. As purposive sampling was the tool, my next step was to ensure that I included the typical, extreme, political, and convenient cases to understand the depth and range of the issue. My intent was also to bind the focus and push the data for redundancy (Rodwell, 1989). For these reasons, I completed interviews with each stakeholder group prior to moving forward to the next stakeholder group. This technique ensured that I reached maximum variation with each stakeholder group.

www.manaraa.com

Initial contact with gatekeepers. Gatekeepers were defined as professionals or organizations that allowed or facilitated access to a sample population of stakeholders (Rodwell, 1998). In this context, the gatekeepers gave access to individuals with mental illness. My initial contact to gatekeepers was primarily to ascertain the feasibility of the inquiry. Gatekeepers such as psychiatrists, psychologists, mental health advocacy groups, and social workers assured me that my inquiry was both timely and vital. These professionals committed themselves and their resources to assist me in gaining access in a respectful and confidential manner.

Sample recruitment. Once Virginia Commonwealth University Review Board (IRB) approved the study, there were a number of recruitment efforts. The recruitment script was followed (as outlined in my IRB) and questions emerged as the interviews progressed. A literature review of civil detainment suggested that different stakeholder groups could contribute multiple perspectives advancing a deeper understanding of the experience. These groups included individuals who were detained, families of detainees, mental health professionals who initiated detainment, law enforcement officials, and judicial professionals. As the inquiry emerged, the individuals who were involved with the phenomenon identified additional stakeholder groups. These additional individuals included rescue squad personnel and emergency room staff.

There were a number of recruitment efforts for each of the stakeholder groups. They were as follows:

Table 2. Recruitment Efforts

Stakeholder Group	Recruitment Efforts
Individuals with mental illness	A. mental health professionals such as psychiatrists and licensed clinical professionals B. mental health advocacy groups

www.manaraa.com

Families	A. mental health professionals such as psychiatrists and licensed clinical professionals B. mental health advocacy groups C. community service board staff
Mental Health Professionals	A. mental health professionals such as psychiatrists and licensed clinical professionals
First Responders	A. professional organizations, B. mental health professionals such as psychiatrists and licensed clinical professionals C. medical staff at area hospitals
Judicial System	A. professional organizations

Table 2. This table outlines the five stakeholder groups and the recruitment efforts utilized.

Individuals with mental illness. I identified individuals with mental illness that had experienced civil detainment as the first stakeholder group as my goal was to promote social justice by giving voice to the individuals who typically were not "heard" (Rodwell, 1998). Gatekeepers (psychiatrists, medical physicians, grass roots organizations, mental health organizations, and licensed mental health clinicians) referred such individuals to me. Gatekeepers were used for the identification and recruitment of individuals who met the following criteria:

a. Diagnosed with mental illness

b. Experienced confinement under a temporary civil detention

c. Detained in the Commonwealth of Virginia

www.manaraa.com

d. Detained after 7/1/2008

e. Considered mentally stable

f. Competent to agree to the study

g. Between the age of 18 and 75

In addition, the individuals with mental illness had to be willing to participate in the interview and the subsequent member check. They also needed to be able to complete the interview without the risk of negative consequences and remain mentally stable if not chosen for the inquiry.

Throughout the recruitment process, confidentiality and privacy of the participants were protected through a multilevel recruitment approach. Gatekeepers were given a packet of information consisting of introductory letters (Appendix A), recruitment scripts (Appendix B), and release of information forms (Appendix C). Gatekeepers communicated details of the study to potential study participants utilizing the recruitment script. I also requested that any gatekeeper with interested participants have each individual sign a release-of-information form. The signature allowed the gatekeeper to contact me, the researcher, with the client's name and phone number.

Initial recruitment effort. The initial recruitment effort involved developing a list of professionals and groups who were likely to assist me. I contacted approximately 50 professionals through email. In addition, using postal mail, I contacted 65 professionals in the public databases such as the Clinical Society of Virginia and the Department of Health Professionals.

This initial recruitment effort resulted in 10 responses. Five professionals indicated the study was important and timely but did not have individuals on their caseload who met criteria.

www.manaraa.com

Five professionals said they were not interested in discussing the study with individuals on their caseload because the study might be contraindicated to the individuals' stability. The criterion that was most difficult to meet was a detainment experience after 7/1/2008. I began to receive referrals in May 2011 from professionals who I contacted personally when I inquired about the feasibility of the inquiry. In this way, I received two referrals for individuals who had been detained.

Second recruitment effort. A second recruitment effort involved organizations acting as gatekeepers. These organizations made the decision to pass along my contact information to individuals. These individuals could then determine for themselves whether to contact me or not. The National Alliance for Mental Illness and the Virginia Organization of Consumers Asserting Leadership (VOCAL) were supportive of my study and agreed to distribute recruitment scripts at their annual conference May 2012. In addition to the distribution of my recruitment scripts, I attended the annual VOCAL conference and offered participants opportunities to self-identify. The director of VOCAL acted as a gatekeeper, utilizing the recruitment script. Five individuals self-identified; three were in treatment, stable, and capable of understanding and agreeing to the consent process. Two were denied because they did not meet the timeline criteria of detainment after July 2008.

My initial plan was to interview five individuals between the ages of 18 and 75 who had been involved in civil detainment post July 2008. Individuals were chosen from the available sample population to achieve maximum variation. I chose individuals based on criteria detailed in the IRB. I strove for diversity among the participants in order to deepen my understanding of civil detainment versus a desire for generalizability (Table 3).

www.manaraa.com

Whenever an interested individual made contact, I evaluated the individual against the study purpose and criteria to make a decision about inclusion. I gathered preliminary information, such as the date of the civil detainment; the individual's location, age, and gender; and current treatment status. I then made contact to secure each individual's agreement to participate; determine an interview location and time; and identify specific needs the individual might have.

The initial stakeholders. My first stakeholder group of individuals with mental illness who had been detained was comprised of three individuals with mental illness referred from medical professionals and three individuals who self-identified for a total of six. The first group of individuals included two men and four women. I made a decision to interview a sixth as I felt the additional individual would represent a greater diversity; he increased the number of men from one to two.

The locations of the detainment included northern, western, and eastern Virginia, occurring in both metropolitan and rural areas. All of the participants' experiences met criteria for inclusion. Although it was not a criterion of the sampling process, all six civil detainment experiences resulted in commitments ranging from three to 24 days. This emerged as one limitation to my study as I was unable to obtain the perspective of an individual detained but released from the hospital prior to the commitment process.

At the completion of each interview, I asked the participants to identify stakeholder groups who they believed had been instrumental in the detainment process. This questioning directed me to other stakeholder groups. Soliciting stakeholder groups who had been important within each individual's detainment process developed a road map that directed me to other stakeholders. Stakeholder populations emerged as follows:

www.manaraa.com

- Members of families involved with civil detainment
- Members of the mental health profession (clinical therapists and psychiatrists who evaluated and initiated the process of civil detainment)
- First responders (police, rescue, and community service board staff)
- Professionals in the judicial system

My goal was to interview between three and five individuals from each stakeholder population or until saturation, defined as reaching the point where no new information was being shared or there was a redundancy in the information.

Families. Families were the next stakeholder group as the individuals with mental illness identified this group as most important to their civil detainment experience due to their level of involvement and support. In addition, remaining committed to social justice; I interviewed the families after the individuals with mental illness as they were not as powerful as the professionals involved, but more powerful than the first stakeholder group (individuals with mental illness).

The recruitment of families involved a distribution of the recruitment script to 10 public mental health offices, 25 medical offices, NAMI, FOCUS, and 25 private clinicians. My sample population consisted of six families directly involved in the civil detainment of a family member. With the family stakeholder group, I interviewed one family member that was the husband of an individual who was detained and subsequently interviewed in this inquiry. A second family member was indirectly involved in the civil detainment experience, as he (an adult son) was not living with the family member when she (his mother) was detained. Due the duality nature of the first family member's relationship and the indirect relationship of the second family member's relationship, I decided to add an additional family member to the overall stakeholder

www.manaraa.com

group to extend the quality of the sample. One family member was denied inclusion because the detainment experience occurred prior to July 2008.

Mental health professionals. The family member stakeholder group indicated that the mental health professionals involved in their experience were vital. For this reason, the stakeholder group of mental health professionals was interviewed next.

Recruitment of mental health professionals was accomplished through a mailing of recruitment information to 25 professionals across Virginia. The mailing list was compiled from public databases, such as the membership roster of the Virginia Clinical Social Work Society, web sites of clinicians, medical offices, and mental health professionals' offices. The sample population consisted of five clinicians from various geographic locations in the Commonwealth who worked in a number of capacities. These professionals included a private psychiatrist, a licensed clinical social worker (LCSW) for a private hospital, and LCSWs in public community organizations. No individuals were denied inclusion to the inquiry.

First responders. During my interviews with the individuals with mental illness, families, and mental health professionals, each of the stakeholder group indicated that first responders should be recruited and included. For this reason, first responders emerged as the fourth stakeholder group. This group was comprised of two law enforcement professionals, one-rescue squad personnel, three community service board evaluators, and one emergency room staff.

The recruitment process for first responders followed the same pattern as above. Using mailings, emails, and previous contacts, seven individuals from various parts of the Commonwealth were recruited and interviewed. Due to the diversity of this group and

www.manaraa.com

information offered to me in the interviews, I decided to increase my sample size from five to seven.

Judicial. As the data collection process advanced, stakeholders such as magistrates, lawyers, and judges emerged as potential stakeholders in the experience. However, the data suggested that involvement from this particular stakeholder group was peripheral in nature to the experience of civil detainment. All four groups spoke of this stakeholder group with emotional distance and verbalized a perception of lack of connection between the judicial professionals' experience and the detainment process. As this stakeholder group had the most power and they were identified as peripheral in nature, they were the last stakeholder group to interview.

After discussions with my peer reviewer, a decision was made to interview one member of the justice profession. It was determined that the interview would help me assess whether the information was pertinent to understanding the experience of detainment. I initiated the recruitment process as I had with previous groups (web sites, public databases, etc.) and recruited and interviewed a participant of the justice system. This individual had served in three roles identified above: magistrate, lawyer, and judge.

After the interview, it was clear that the individual had experience with the commitment process rather than the detainment process. After further discussion with my peer reviewer, I decided that I would not interview others in this group. The interviewee in the judicial stakeholder group had a different experience from the other participants. Subsequent data analysis proved this was a sound decision.

The sample size, geographical location, and demographics (such as race and gender) for the participants are outlined in Table 3.

Table 3–Demographics

www.manaraa.com

Participants	Female	Male	Total
Ethnicity			
Caucasian-American	13	8	21
African-American	0	1	1
Asian-American	1	0	1
Ethiopian-American	1	1	2
Total Ethnicity	**15**	**10**	**25**
Role			
Detained Individual	4	2	6
Family Member	3	3	6
Mental Health Provider	5	0	5
• Psychiatrist	1/5		
• LCSW	4/5		
First Responder	3	4	7
CSB staff	3/3		
Rescue Squad personnel		1/4	
Emergency Room Doctor		1/4	
Law Enforcement Personnel		2/4	
Judicial	0	1	1
Total Role Categories	**15**	**10**	**25**
Geographical Location			
Urban	9	4	13
Suburban	4	5	9
Rural	2	1	3
Total Geographic Locations	**15**	**10**	**25**

Table 3: This table outlines the specifics of the stakeholder groups' demographics.

Phase II-Focused Exploration

My phase two of this constructivist inquiry involved a formalized data collection and data analysis process (Rodwell, 1998). The purpose of this phase was to create a circular conversation known as the hermeneutic circle, wherein perspectives and insights were considered and individuals' unique perspectives were shared, tested, and evaluated. The use of the hermeneutic circle began the formation of data analysis (Rodwell, 1989).

www.manaraa.com

Foreshadowed questions identified earlier became the starting place for data collection (Rodwell, 1998). Individual face-to-face interview sessions comprised of open-ended questions with probes were used to invite study participants to share experiences related to the overarching areas identified in the literature: suspected dangerousness, threat to liberty and security, and consequences of detainment. My foreshadowed questions centered on understanding the individual's experience in relation to his or her other involvement with civil detainment.

The following open-ended foreshadowed questions served as point of entry for the interview process (Appendix J).

1. Would you share your feelings, thoughts, and understanding of civil detainment law?
2. Would you share your experiences with civil detainment?
3. Would you share how the experience of civil detainment has affected or not affected your perception of yourself or individuals with mental illnesses?

During the course of the inquiry, the questions were altered in a response to the participants' statements about what the questions "should be." The participants related the primary questions needed to center on the experiences with civil detainment rather than the experiences with the legislation. The participants expressed thoughts and feelings that the civil detainment law lacked relevance to their experiences. For this reason, the order of the questions changed to the following:

1. Would you share your experiences with civil detainment?
2. Would you share how the experience of civil detainment has affected or not affected your perception of yourself or individuals with mental illnesses?
3. Would you share your feelings, thoughts, and understanding of civil detainment law?

www.manaraa.com

In addition, the individuals suggested that use of words such as stigmatization be altered to "stand-offish". For this reason, the probe that inquired about being stigmatized was altered to whether he or she experienced others being standoffish.

My experience with constructivist methodology and my clinical practice skills allowed me to use tacit understanding to probe the experience of civil detainment in terms of recovery, dangerousness, and human dignity. Tacit knowledge, constructed from the unique experiences of an individual, is difficult to articulate in a concrete manner (Rodwell, 1998). Much like practice wisdom, it involved my understanding of nonverbal interactions such changes in body posturing, facial expressions, and tone and inflection of the interviewee's voice.

Data collection. Prior to the collection of any data, I received training on the qualitative software program NVivo and determined this program's ability to store my data. In addition to the training that I received with NVivo, I also worked with the NVivo software program on another qualitative research study, furthering my expertise with the software. NVivo enabled me to import, sort, and analyze files, Microsoft Word documents, PDFs, rich text documents, and plain text documents. The software allowed me to work with or without transcripts, analyzing material straight from PDF files. It also allowed for the development of transcripts, memos, or text files as the inquiry emerged.

The preferred manner of data collection in constructivist methodology was the constructivist interview (Rodwell, 1998). My process of collecting data also included the use of journals, nonhuman data sources, and human data. The face-to-face interviews were developed to encourage a mutual search for meanings shared through respectful listening and the exchange of ideas and information. I utilized these efforts to ensure a respectful environment for the interview.

www.manaraa.com

Prior to initiation of the interview, the participants read and signed informed consent forms. In addition, I verbally reviewed the consent with each study participant in order to address any questions and to ascertain that the interviewee fully understood the risks involved. I also explained to the participants how much time and energy would be required to complete the interview and the final member check. I clarified that participation was voluntary and that withdrawal from the inquiry could happen at any time without retribution. I used an interview guide or script that contained the foreshadowed questions and probes. Initially the interview script was in its original format, but as the process unfolded, the script was altered to address the opinions and concerns of the participants.

The interview script was fluid; with each interview, additional concepts or connections emerged, irrelevant concepts were removed, and interviews became more focused. Once the interview had begun, questions were asked in a broad manner with subsequent probing for clarification and deepening the understanding of the answers' content. The answers were recorded in written form and non-verbal data was also noted in the same manner. These field notes were utilized as a strategy to triangulate and extend the information.

My in-depth face-to-face interviews allowed the complexity of the topic to be fully explored and understood in terms of each individual's reality. An interview time and location was set up at the convenience of the individual with an expectation the interview would last 50-60 minutes. I found that participants usually wanted to share their stories completely and thoroughly. This resulted in interviews that ranged from 60 minutes to 100 minutes. As the interview neared 50 minutes in length, I would prompt the individual that our agreed upon time of 60 minutes was about finished. During 23 out of 25 interviews, the individual asked for additional time.

www.manaraa.com

Within 24 to 48 hours of each interview, I reviewed the interview material, made grammatical corrections for formatting, and uploaded the interviews into NVivo. Once the information was uploaded, I proceeded to break the word data into smaller units of analysis. I then began coding units.

I also recorded my personal reactions two ways. After each interview, I recorded my initial thoughts into a mini recorder. This allowed me to capture my emotions and information gleaned once I stopped taking formal notes. Upon my return to the office, I wrote recorded thoughts and feelings in a reflexive journal. Any decision made regarding alterations in methodology was recorded in a methodological journal. I utilized these two journals in data analysis since they increased the tacit knowledge that I, as the human instrument, provided.

Termination of the interview occurred when the data shared was redundant or nonproductive – or if the interviewee displayed fatigue or resistance. At the closure of each interview, I asked each interviewee to suggest any other questions that may be useful for future interviews. I also summarized what I had heard and asked for confirmation that I had captured the interviewee's experience as he or she perceived it. This served as a preliminary member check.

My experience with constructivism and familiarity with the field of study assisted me in clarifying the terminology with the participants used to describe their experience. In addition, tacit knowledge, reflexive journals, the peer-review process, and member checks aided in construction of new questions which deepened my understanding and the meaning of civil detainment. Thus, the hermeneutic circle shaped more pointed and directed questions.

The hermeneutic circle. The hermeneutic circle is defined as "a sharing of perspectives regarding concerns and issues presented, considered, evaluated, understood, rejected or

www.manaraa.com

incorporated into an emerging understanding of the phenomena" (Rodwell, 1998, p.82). During my interviews, participants discussed, considered, and validated personal meanings of the civil detainment experience.

I used hermeneutics, the study of text, to deconstruct the interview data and develop an understanding of the "whole" experience through the process of understanding "parts" of the experience. This deconstruction of the experience within the interviews and during member checks developed the hermeneutic dialectic, which occurred when "perspectives were compared and placed in contradiction" (Rodwell, 1998, p. 256).

One example of this dialectic manifested itself in family members' perceptions and experiences of the first responders. I shared some of these perceptions and experiences with the stakeholder group of first responders to encourage a discussion that confirmed or disputed the information and, thus, extended my understanding of the process of civil detainment. However, I shared the information without jeopardizing confidentiality and prevented any loss of anonymity by altering identifying information. As different parts of the civil detainment process were better understood (i.e. the transportation between the hospital and the courts for the civil detainment hearing), a greater understanding of the whole experience emerged.

Through a dialectical process of comparing and contrasting individual constructions and member checking, I developed a draft of the case study. This draft, a "data dump" (Lincoln & Guba, 1985, p. 367), incorporated and cited all categorized units. The foreshadowed questions remained more or less the same in structure, thus allowing for the development of major constructs.

By first interviewing individuals who were detained, I ensured that the voices of the individuals with the least amount of power were heard and included. As a human instrument

www.manaraa.com

within the hermeneutic process, I acted in the role of inquirer and witness. I recorded the information shared, probed more deeply when concerns and paradoxes emerged, and monitored for stories present but not shared – such as the lower economic status of the individuals who had been detained. Another example of unacknowledged experiences occurred when I observed the participants' physical reactions to the interview. Relying on my tacit knowledge, I began to notice a pattern of compartmentalization of events, a coping technique that was particularly evident in relation to memories that may have been painful. With gentle probes, I was able to help participants bring memories of the detainment experience from the unconscious to the conscious. This experience was honored and as it emerged, I included the experiences in the case report, through grounding it in the data.

Each specific stakeholder group (i.e. families, mental health professionals) was interviewed prior to moving onto the next stakeholder group, thus advancing the dialectical process. This interview process allowed me to include the voices of previous groups in the subsequent sets of interviews and enhanced the participants' experiences dialectically. Through regular member checks during and at the completion of each interview, I clarified and extended the meaning of civil detainment. After all stakeholder groups were interviewed, I then asked two individuals with mental illness who had been detained to review the gathered information and offer any reactions. There were no disagreements at this point of the member checking process.

I also acted as liaison among study participants' various constructions. As a liaison, I shared information from member to member and group stakeholder group to stakeholder group. This allowed each interviewee to have his or her own reactions to others' interpretations, thus facilitating the hermeneutic circle. This also allowed any constructs that emerged from stakeholder groups to be shared as a theme to the other stakeholders. As the process moved from

www.manaraa.com

one interviewee to another interviewee, the hermeneutic circle was developed. This augmented the study's capacity to educate and empower the participants as I discovered meanings emerging from the analysis of the data.

Nonhuman data sources. Additional data sources were included in my analysis, such as records and documents available through public databases (i.e. the civil detainment policy, the uniform prescreening form) or documents offered by the participants. These documents were utilized to supplement the inquiry and increase the understanding of important aspects such as the policy. An example of this was the legislation that offers the option to the police to determine whether an assessment by a CSB worker was needed or not. The journals I described earlier helped maintain the direction of the inquiry. They also acted as resources for meaning making and were used as tools for managing the contextual aspect of data collection and analysis. All journals were used to develop audit trails.

Inductive data analysis. Inductive data analysis has been defined as "the formal data analysis of verbal and nonverbal data" (Rodwell, 1998, p.58). The manner of analysis moved from the specific to the general as each unit of data was analyzed. This form of analysis ensured that fixed boundaries did not limit the analysis. This extensive process of data analysis also respected that all data were relevant. The data analysis process involved several stages of constant comparison and coding. My first stage involved typing the raw data from each interview to ensure that all spoken words were included. NVivo 9 allowed each interview to be coded and contained within the software program.

I then transcribed the field notes and the extended field notes to ensure that all my observations, thoughts and feelings were included. Next, I cleaned the interview data of any extraneous information such as words like "um" and began the process of unitizing the data.

www.manaraa.com

Unitizing has been defined as the process of deconstructing all data into the smallest fragment of understandable data (Rodwell, 1998). I proceeded to deconstruct the field notes and interviews into the smallest unit of data. In the process of unitization, I arrived at 3,472 units of data, otherwise known as free nodes in NVivo. I then coded each unit of data, developing a trail that could be followed in the auditing process.

My codes were built from the foreshadowed questions, the working hypotheses and the sample frame. A code may be "1mhpd13" which meant that the first (1), mental health professional (mhp), spoke about dignity (d) on line 13 on the interview transcription (13). My next step was to utilize constant comparison examining each unit of data against all other units of data. Rodwell (1998) states that constant comparison is the comparison of each unit compared to all other units of data and are utilized in an effort to produce grounded theory. My goal was to find both similarities and differences between the units of data through this process.

Using inductive analysis, I was able to identify similarities and differences between the units of data. I clumped similar units of data together and labeled the "clump" otherwise known as a tree node in the NVivo software program. In NVivo, a free node is one unit of data whereas a tree node is larger abstract theme that consists of more than one free node (see table 4). Each tree node was labeled and coded to reflect the theme that emerged. The process resulted in approximately 58 tree nodes.

My second stage in the data analysis process involved analyzing each tree node to ensure that the data included within it was with similar units of data. When I found data that required further differentiation, I created, labeled and coded a sub-node. I then compared each tree node to all other tree nodes looking for similarities, differences, and constructs. I explored relationships among the tree nodes in various combinations. As similarities emerged, I

www.manaraa.com

combined the tree nodes into new higher-level categories that represented the constructs that emerged. I labeled and coded these categories to reflect the theme that emerged. This constant comparison analysis reduced the number of tree nodes from 58 to 15 categories.

My third stage in the data analysis process involved analyzing each of the 15 categories to ensure that each category included similar tree nodes. When I found a tree node that required further differentiation, I created, labeled and coded a sub-node. I then repeated the process of constant comparison of the 15 categories exploring relationships. Through this constant comparison process, the similarities found between the 15 categories resulted in the establishment of five overarching categories at a higher level of abstraction. I labeled and coded each of these five categories reflecting the constructs that had emerged at a greater level of abstraction. These final categories, or tree nodes, and the relationships among them became the focal points (grounded theory) for understanding the meaning of the data.

An example of the node system is as follows:

Table 4. An example of the node system of coding

Code	**Title of Node**	**Type of Node**
HR	**Human Rights Application**	**Tree Node**
A	*Autonomy*	*Sub-Tree Node*
A1	Lack of autonomy	Free Node
A2	Attempts at autonomy	Free Node
A3	Advocacy for autonomy	Free Node
A4	Loss of autonomy	Free Node
A5	Lack of advocacy for autonomy	Free Node

www.manaraa.com

D	*Cognizant*	*Sub-Tree Node*
D1	Yes	Free Node
D2	No	Free Node
D3	Confusion noted	Free Node
E	*Ethics*	*Sub-Tree Node*

Table 4. The table demonstrates the framework of one tree node with the attached sub-tree nodes and free nodes.

Grounded theory building. Rodwell (1998) stated that grounding theory in constructivist inquiry was a "theory only in that it is the final product of data reduction and interpretation" (p.154). Through inductive data analysis, relationships became visible and categories were created with increasing degrees of abstraction through the inductive analysis process (Rodwell, 1998). Based on my understanding of the five categories, I created a conceptual pictorial diagram, or schema, of the categories as I understood them. I developed a number of drawings in an effort to capture a holistic and sophisticated structural representation of the meaning of civil detainment.

Once I had completed the schema, I created the case report based on the meaning making that occurred during the data analysis process as well as the creation of the picture. A case report, a narrative that uses thick description (Geertz as cited in Rodwell, 1998), was written and revised numerous times in an effort to give readers a vicarious experience of the inquiry (Rodwell, 1998). Out of 3,472 units of data, 3,470 units of data were incorporated into this report to ensure that the voices of all participants were represented. The remaining 2 units of data were discarded and not included because they were superfluous. I discerned the contextual

www.manaraa.com

reality of the experience of detainment and developed a theory about the experience of civil detainment.

I developed an initial case report as the data was analyzed. As newer and more informed constructions of the case report were created, subsequent drafts became more sophisticated as I deepened my understanding of the complexity of civil detainment. In the process, the case report moved further away from the raw data and closer to the conceptual interpretation (Guba & Lincoln, 1985; Rodwell, 1998).

The final case report was framed by the following five major constructs. The labels for each of the five constructs and examples of the sub-categories were as follows:

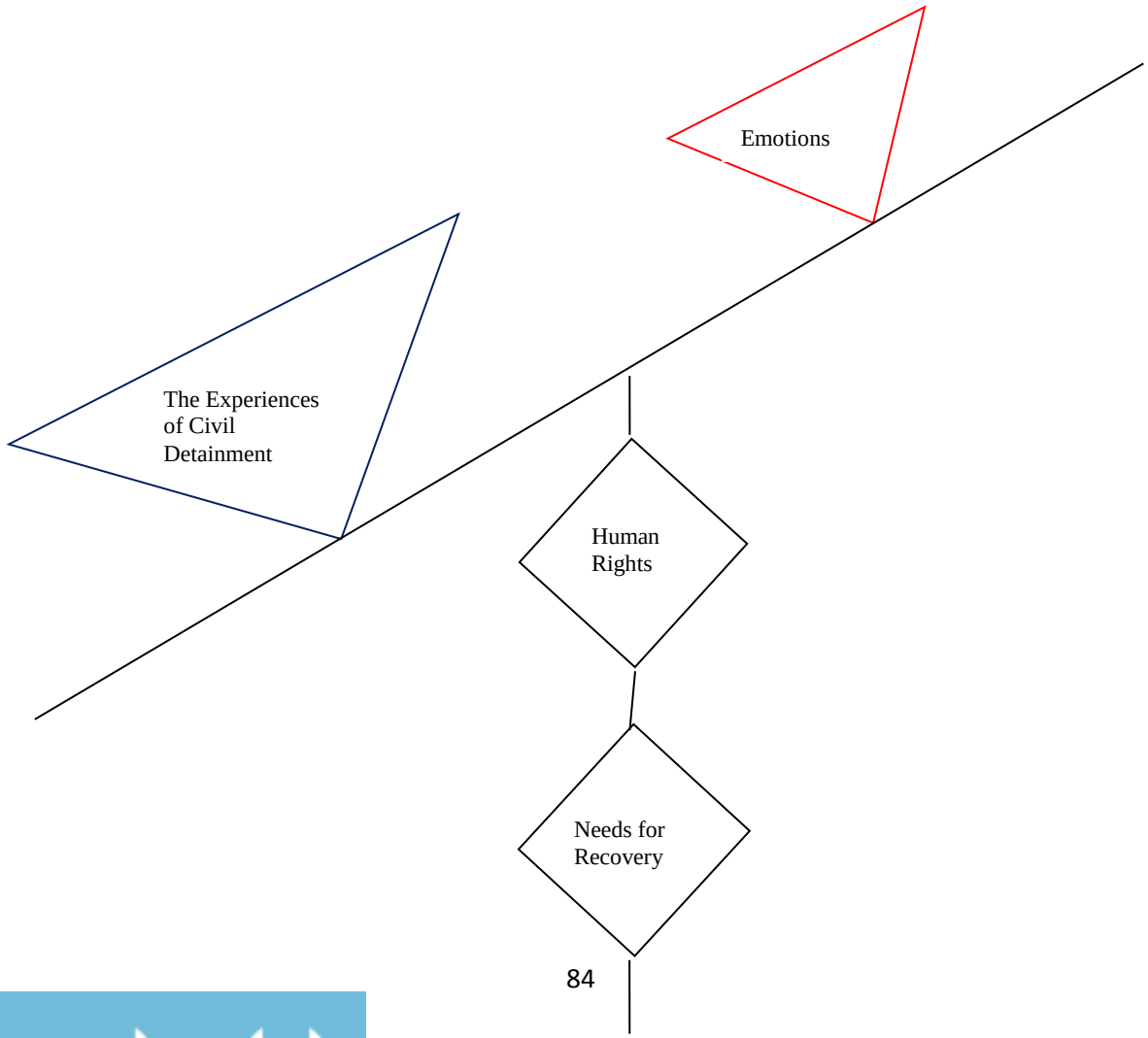
- The influences that impact ; including resources, severity of illness, CIT training of professionals
- The application of human rights: including examples of dignity violations, rights read at the detainment hearings
- The needs for recovery: including alternative forms of treatment, support of the family, access to treatment
- The experience of the individual: including the wait for a bed, the use of handcuffs, the rejection by family members, the stories of the participants
- The emotions that emerged: including anger, shame, relief, sadness

The five constructs that emerged became the cognitive map of the data: my way of organizing and making sense of the data. This cognitive map also helped me formulate my conjectures about connections among the categories identified. The graphic illustration and the summary were then returned to all study participants for a review and confirmation of accuracy.

www.manaraa.com

The goal was to ensure that all participants felt that their voices were represented in the illustration and summary.

Figure 2 Conceptual Model of Thematic Analysis



www.manaraa.com

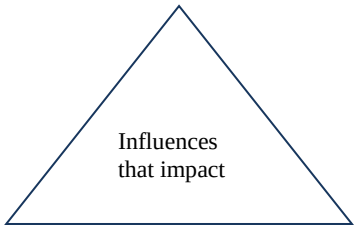


Figure 2 Conceptual Model of Thematic Analysis demonstrated the precarious balance that the experience of civil detainment and the resulting emotions have with the influences that impact, the needs for recovery, and the application of human rights.

Phase III-Comprehensive Member Check

A comprehensive member check is defined as a technique that facilitates feedback between the participants and the researcher and is used to improve accuracy, credibility, dependability, confirmability, and transferability (Rodwell, 1998). Once I finished writing the final case report, I initiated the final comprehensive member check. I first attempted to contact each participant and requested input into the preliminary case report. I sent the written report (Chapter 4) to all participants along with the final member check questions (Appendix G). My goal was to ensure that the participants felt that their voices were heard in the final report (Guba & Lincoln, 1989; Rodwell, 1998). They were asked to read the case study report and to answer following questions:

- Is your perspective accurately reflected in the case study?
- Did you gain new understanding about the experience of civil detainment from others' perspectives? If yes, explain. If no, please explain.
- Are there factual or interpretive errors? Please be specific.
- Are there any comments you would like to make?

Of the twenty-five participants, seven responded to the questions. I received one response by phone, three by mail and three by email. The participants that responded included two from

www.manaraa.com

the stakeholder group of individuals who had been detained, two from the stakeholder group of family members, two from the stakeholder group of mental health professionals, and one from the first responder stakeholder group. This final member check was an essential step in completing the hermeneutic process; it allowed the final case report to contain the negotiated hermeneutic results. One interviewee related a desire to include a greater focus on the negative consequences to the individual with mental illness. A second interviewee related a desire to include the grief and loss that families experience when they realize that their son or daughter will never be what the parents had envisioned at the child's birth. I included the additional information within the case report and then verified with the participants that their perspective was included accurately. In addition, I documented my decisions about inclusion in the methodological journal.

Criteria for Rigor

Rigor was assessed through auditing the trustworthiness and authenticity of the inquiry's methods and conclusions. The criteria used to judge trustworthiness were: dependability, confirmability, credibility, and transferability. The case report had sufficient internal logic to be explainable to an outside party and the auditor, thereby demonstrating authenticity.

Monica Leisey, Ph.D., MSW completed the audit process of trustworthiness and authenticity. This process included: "reading the final report, randomly selecting 10 superscripts, tracking the superscripts back through NVIVO identifying the node to which the superscript was connected, tracing the individual codes within each node to the raw data as it was entered into NVIVO, reading the methodological journal, reading the reflexive journal, and reading the peer-review journal" (Appendix H, paragraph 3).

www.manaraa.com

Trustworthiness. Rodwell (1998) defined trustworthiness as one standard by which the quality of the research product is asserted and demonstrated. If the inquiry was trustworthy, it produced confidence in the results. Criteria for trustworthiness included: credibility, dependability, confirmability, and transferability. Throughout the study, I worked towards promoting trustworthiness in all aspects of the study.

Credibility. Rodwell (1998) defined *credibility* as "a measure of rigor that demonstrates the findings are believable" (p.245). Lincoln and Guba (1985) identified several activities that increased the probability of credibility. These activities included prolonged engagement, participant observation, triangulation, peer debriefing, and member checking.

Prolonged Engagement. Prolonged engagement was defined as the activity of "hanging out" in the environment to come to know the contextual aspect of the phenomenon (Rodwell, 1998, p. 260). In this research, prolonged engagement occurred through an extensive literature review, involvement in relevant trainings, meetings in the Commonwealth of Virginia, and interviews with individuals who were involved in civil detainment. Throughout the inquiry, I searched for new and relevant information pertaining to the new legislation and the process of civil detainment such as written debates in professional literature, which considered whether prolonging the detainment period would increase recovery rates.

Triangulation. Triangulation was used to crosscheck the case report information to the multiple data sources. Rodwell (1998) described triangulation as the process of comparing data sources ensuring the information held up under evaluative scrutiny. I used continual cross-checking, assessed for alternative perspectives, and the searched for constructs from the convergence of multiple and distinct sources of information as a way to achieve triangulation.

www.manaraa.com

My efforts at triangulation were recorded in the reflexive and methodological journals and later audited by my outside auditor.

Peer Debriefing. Rodwell (1998) stated that peer debriefing involved working with an individual who was uninvolved with the project and yet had experience and knowledge of the methodology. I met the requirement for peer debriefing by working with an individual who was uninvolved with the project. He was qualified (Appendix I) to comment on my work as he had a full and deep understanding of the process of constructivist inquiry and was capable of confronting the researcher's potentially defensive stance on personal beliefs. The debriefer, Justin Lee, challenged me with difficult questions similar to those that might be posed by a clinical supervisor. His involvement throughout the process assured that the construction of the information was collaborative. He ensured that I remained aware of the biases in my perspective and understood my behavior during the research process. Mr. Lee and I met monthly for 60 to 90 minute sessions from March to September 2011. We both kept separate debriefing journals that were then incorporated into the results and the analysis in Chapter 4.

Member checking. Member checking has been defined as the process of formal and informal testing of the information shared by the individuals interviewed in an effort to achieve convergent validation (Rodwell, 1998, p.99). I initiated member checks during the first interview and continued through the case study drafts. The member checking process included clarification of information received from participants, review of the case study drafts, and feedback on the final project, the case report and lessons learned, from study participants. This process was on going so that participants could verify that I understood their perspective and accurately reflected their construction of their experiences (Guba & Lincoln, 1989; Rodwell, 1998). NVivo 9 was used to record the results of member checking.

www.manaraa.com

Dependability. Rodwell (1998) stated that *dependability* was the assurance that "all procedures employed to collect, analyze, and interpret data fall within the expectations of constructivist research practices (p.99). Dependability was demonstrated through the tracking and accounting for the inevitable changes that occurs in a constructivist research design. Dr. Leisey (Appendix J) assumed the job of auditing and was able to identify a number of methodological shifts that occurred during the inquiry process and ensured that they were appropriate for this inquiry. Since this inquiry had an emergent design, changes were inevitable and expected. In order to follow a constructivist approach, the most important element was to document those changes. For instance, during my interview process, I altered the sequencing of questions and changed the language to fit specific interview situations. However, these changes were carefully documented in the reflexive and methodological journal. There were also thoroughly discussed in my peer review sessions to ensure that the changes were dependable and appropriate. Thus, with a peer-review journal, the methodological journal, and the reflexive journal, an audit trail was established that could trace the rationale for the change in the inquiry (Appendix H).

Triangulation demonstrated and supported dependability. All face-to-face interview raw data collected was linked to journals as well as to the reconstruction and synthesis of the data (Rodwell, 1998). These records of data were uploaded into NVivo and deconstructed into 3,472 units of analysis. The units of analysis were then coded into the free nodes. As some units of analysis were coded into multiple free nodes, 6,079 units of data were created. This created five level coding patterns that resulted in 15 major free nodes, which then developed as sub-tree nodes under the final five tree nodes. After each interview, a summary impression was written

www.manaraa.com

and included in the data records. During the process of coding, a "memo" was included in the NVivo program that allowed for tracking of each stage of the analysis.

Decision rules, the details of each category and subcategory, were developed and identified in NVivo. This allowed the auditor to ensure a logical process was completed and the audit was thorough. Analytical categories were identified as tree nodes that described the category properties. Dr. Leisey examined in detail the linkage between the final report and the raw data, tracking the superscripts within the final to the raw data to ensure accuracy and consistency. Ten superscripts were chosen at random from the final report for examination. For each of the 10 superscripts, the first five coded data units were tracked through the NVivo9 software so that fifty coded entries were tracked. This auditing process allowed Dr. Leisey to establish confimability. She could see that the final report is grounded in the data and ensure that the nodes within the NVivo software are logical and explanatory (Appendix H).

Confirmability. Rodwell (1998) stated *confirmability* was an aspect of rigor that demonstrated that the research results were linked to the data collected during the inquiry (p. 254). My goal was to ensure that the results were linked to the data units. To accomplish this, an audit plan was developed that outlined the steps taken to deconstruct each interview into small units of data. The steps taken also included incorporating each unit of data into the reconstruction of the civil detainment phenomenon.

The audit examined the member check feedback and the inclusion of multiple perspectives to determine that conclusions were firmly grounded in the data. This ensures that the tentative lessons drawn from my data may be appropriate to the lived experience of civil detainment (Appendix H). The auditor verified the consistency, appropriateness, and accuracy of the content and the procedures for analysis (Lincoln & Guba, 1985). The auditor's results

www.manaraa.com

verified the study's trustworthiness in all dimensions: confirmability, credibility, dependability, and transferability (Appendix H).

Transferability. Rodwell (1998) stated that *transferability* was "a measure of research rigor that demonstrates sufficient information about the context and the phenomenon of civil detainment is provided in the case report" (p.263). Transferability was difficult to achieve since the topic of civil detainment is contextually bound. It was my job to write a case study report. A case report that would allow an informed reader to determine if the information gathered would be useful in another setting.

I believed that maximum variation would provide insights that would be useful to other individuals and stakeholders experiencing civil detainment. The use of "thick description" in my case report i attested to their transferability and ensured an accurate portrayal of the participants' experience, a comprehensive description of the phenomenon, and the usefulness of lessons learned.

Confidentiality and Rigor Protections

I utilized a number of dimensions of trustworthiness that included managing distortions, ensuring privacy, maintaining field journals, and maintaining the audit trail.

Distortions. Distortions, a component of trustworthiness, have been defined as biases or the inability to be evenhanded in the process of mutual shaping of the co-constructions. Such distortions were guarded against by the use of prolonged engagement and peer review. I remained involved with individuals and gatekeepers long enough to develop relationships. At the same time, I monitored my own boundaries and potential for biases through the use of my reflexive journal and my peer reviewer. I also used member checking, triangulation of data, and

www.manaraa.com

assessment of respondent credibility to assure the steadiness, fairness, and impartiality of co-constructions.

Confidentiality. All information within this program was protected by three passwords. No identifying information was available through the software. I removed and replaced all names with pseudonyms. In addition, a strategy for de-identification was built into the inquiry's design. All interviews and conversations occurred in private rooms or in private locations chosen by the participants for their comfort. The confidentiality strategy involved several different elements. Consent forms and raw interview data were kept in a locked file cabinet and within the password protected NVivo software program. The inquiry used a system for assigning a pseudonym to each study participant. An information sheet matched study participant names to pseudonyms. This information was kept confidential, password protected, and stored in NVivo. Study participant names were not included in the data collection process. Neither the principal investigator nor the student researcher shared any details from the interviews that would jeopardize anonymity.

Given the hermeneutic process, all study participants were informed that it was not possible to fully guarantee confidentiality. Study participants were informed that due to the use of natural language, direct quotations, and continuous hermeneutic feedback loops, their personas and positions might have become transparent.

Privacy. Privacy referred to the participant's ability to control who was authorized to know of his or her participation. To ensure privacy, a multilevel approach was utilized during recruitment. Introductory letters were distributed to outpatient therapists, physicians, mental health facilities, and grassroots organizations in the Commonwealth of Virginia. These letters informed these professionals of the research, asked for referrals, and indicated the risks and

www.manaraa.com

benefits of participation. Gatekeepers acquired signed releases from potential participants that were subsequently returned to the researcher. The grassroots organizations, acting as gatekeepers, distributed the information, a process that allowed self-identification. Six individuals were chosen and contacted to achieve maximum variation. The referring clinicians and gatekeepers were not given information about who had agreed or refused to participate. These steps maintained the clients' participation and confidentiality.

The gatekeepers and I assured all study participants that decisions about participation would not affect the quality of service they received or their status of employment. All individuals who expressed interest in being interviewed but were not chosen for the inquiry were notified of their status.

Field journals. There were five forms of journals maintained continuously throughout the inquiry, and they became vital components of the audit trail. The journals included the reflexive journal; the methodological journal; a series of field journals (documentation of the events occurring in the interviews including thoughts, feelings and interactions); expanded field journals (the expansion of the data collected including both written and recalled information – within 24 hours after collection); and a log of day-to-day activities (calendar of appointments). These journals were maintained to demonstrate persistence. Evidence of emergence and of my growth in relation to the inquiry recorded in the journals ensured that my tacit knowledge was not lost in the process.

Audit trail. The audit trail consisted of all raw data linked to the field journals and to its abridged form, in other words: "data reduction and analysis products" (Rodwell, 1998, p. 106). This trail included the following:

a. All versions of data reductions

www.manaraa.com

b. Products resulting from these reductions

c. The participants' and the researcher's aims and dispositions

d. The development of the human instrument

e. The case report (Rodwell, 1998)

I maintained this trail through my reflexive and methodological journals, field notes, and NVivo, allowing for transparency between the data and final product.

Authenticity. Rodwell (1998) stated that authenticity focused on the quality of the research process was composed of fairness, ontological, educative, catalytic and tactical aspects (p. 253). Authenticity ensured the quality of the overall process was achieved through evenhanded representation of the various experiences communicated during the study.

The potential for change that accompanied the construction of meaning was a major aspect of authenticity. There was no inclusion of a minority report since it did not emerge in this inquiry. Four dimensions of authenticity were demonstrated: (a) fairness, (b) ontological authenticity, (c) educative authenticity, (d) tactical authenticity.

Fairness. Fairness, defined by Rodwell (1998) as an evenhanded representation of various aspects of the dilemmas associated with civil detainment, was demonstrated through the presentation of a balanced view of different constructions and through the member checking process. To present a balanced view, I first interviewed people who had been detained to ensure that their voice was revealed and included in the hermeneutic process. The order in which I scheduled the interviews gave voice first to those who are least powerful; the detainees. Through the organizational order of the interviews, potential power differentials were decreased. The order of the interviews and the multiple perspectives increased the sophistication of the meaning

www.manaraa.com

and enhanced understanding of the experience. Multiple perspectives and member checking feedback were incorporated into the final report, firmly grounded in the data. Dr. Leisey was able to confirm that the inquirer had provided opportunities for all perspectives and experiences to be heard (Appendix H).

Ontological authenticity. Ontological authenticity "attends to the construction and reconstruction of a person's perspective as it becomes more sophisticated" (Rodwell, 1998, p. 108). This construction and reconstruction of perspectives spoke to the increased awareness of the complexity of the phenomenon of civil detainment. In order to create such authenticity, I encouraged individuals and stakeholders to reflect and expand on others' perspectives throughout the inquiry.

Lincoln and Guba, (1986) defined ontological authenticity as the conscious experiencing of the world. My goal, through the interviews and member checking, was to increase the potential for the conscious experience of civil detainment through the process of listening to others' experiences and perspectives. The final case report demonstrated this increased understanding through expanded field notes and the methodological journal.

Educative authenticity. Educative authenticity, defined as becoming smarter about civil detainment, was achieved through study participants' increased understanding of the existence of multiple constructions. All study participants were offered the opportunity to disagree with others' constructions. Allowing for a hermeneutic process of agreement and disagreement, I encouraged clarification and extension of the discourse and facilitated the participants' respect for alternative positions – as supported by the field notes and case report. The study participants agreed that their understanding of the civil detainment experience was extended and enhanced demonstrating educative authenticity.

www.manaraa.com

Dr. Leisey identified a number of entries focused on new levels of awareness that I, the inquirer, had acquired. Prior to this inquiry, as a clinical social worker involved in various roles during civil detainment, I believed that I had a full understanding of civil detainment. I found this to be not true. Entries also demonstrated the realization that I had not been aware of some of the possible consequences of civil detainment, i.e. judges paid twice for the same civil detainment hearing. Dr. Leisey was not able to identify data that explicitly demonstrated the participants' educative and ontological authenticity. She indicated that the inquirer ultimately demonstrated a better understanding of the lived experience of civil detainment and an appreciation for the inherent complexity of the many possible meanings of the phenomenon (Appendix H).

Catalytic authenticity. The fourth dimension is catalytic authenticity, measured by how the research process re-orients, focusses, and energizes the participants to effect change. This may not be able to be determined until after this work is completed and/or years down the road. I may then see participants actively engage in the process of policy development through advocacy as the legislation is reviewed and altered.

Tactical authenticity. The fifth dimension that was achieved in this inquiry was tactical authenticity, which was the result of cumulative changes throughout the research process. Tactical authenticity might be demonstrated if the study participants recognized that full ranges of stakeholders' voices were not heard during the development of procedures for detainment while in transport by law enforcement. Such an understanding might have led to reconsideration about the use of restraint. This form of authenticity was not immediately evident in the results of the inquiry, but may be found later. The participants were provided with the opportunity to have a say in the content of the case report, which was one way to demonstrate tactical authenticity.

www.manaraa.com

www.manaraa.com

Chapter Four: The Experience of Civil Detainment

Introduction

The following case report is based on my interpretation of the interviews that I conducted. I wrote the case report with rich detail to encourage readers to find meaning in the phenomenon (Denzin, as cited in Rodwell, 1998). To maintain a subjective point of view of the data, I chose the case report format. This case report was a "thick description" of the experience and was an effort to meet criteria of transferability (Guba & Lincoln, 1989). This format allowed me to demonstrate the multiple perspectives that were involved in the experience of civil detainment. The case report included information about the individuals' lives, motivations, and feelings that helped the readers understand the context of the phenomenon (Denzin, 1978). The report illustrated the multiple stakeholders' perspectives about civil detainment at the time of the interviews and subsequent follow up. It did not provide causality.

As I mentioned earlier, this inquiry took a constructivist approach, to allow the participants to co-construct the meaning of their civil detainment experiences. Therefore, the case report presented the subjective reality of the individuals who were directly involved in the process and the co-construction of the experience.

This chapter outlines the criteria for judging the quality of a case report and offers guidance in understanding and interpreting the case report. The chapter describes – in writing and in graphic form – the major constructs that emerged from my inquiry and explained the linkage among the different pieces of raw data. The case report constitutes the final section of this chapter.

Judging the Quality of Case Stories

www.manaraa.com

In a constructivist inquiry, a case story's quality is judged on its ability to be transferable (Rodwell, 1998). However, transferability has been defined differently than generalizability. Generalizability has been defined as the process of making predictions based on the case report . A case story has been considered transferable if the reader was able to understand and articulate how the information in the story may also be applicable to others in similar situations. Reading the case report should be an experience that "allows the readers to walk in the shoes of the local actors" (Guba & Lincoln, 1989, p. 223).

The phenomenon my inquiry explored was the experience of civil detainment from different perspectives. The story has been told through the lens of the individuals involved. This allows the reader, you, to understand civil detainment within its context (Rodwell, 1998). Like other case stories, this one was creatively written and "more novelesque than technical in format and intent" (Guba & Lincoln, 1989, p. 224). The literary aspects of the story have been designed to increase the potential for a visceral reaction by yourself. I attempted to weave together the voices – as I understood them – in order to produce a case report that highlighted the significant constructs that emerged through my interviews.

According to Guba & Lincoln (1989), specific criteria were to be used to determine the adequacy of the case report. Below is the list of the criteria that resulted from this inquiry to be applied to the case story (Guba & Lincoln, 1989):

- Were multiple perspectives of civil detainment presented clearly and did the story demonstrate that the researcher and study participants interacted to a level that was sufficient to capture the essence of the experience? Did the story honor each perspective in a respectful and graceful manner?

www.manaraa.com

- Did thick description allow the readers to experience the phenomenon viscerally? Did the story evoke an emotional reaction, not just an intellectual response? Did the story encourage the readers to stretch their perspectives and encourage them to consider alternative perspectives or varying realities?

In meeting these criteria and through the final member check process, the case report became a *joint* construction, co-created by the individuals' interviews and my own interpretations of the experience of civil detainment. In keeping with the conventions of a case report, the resulting document was a joint experience owned by all (Rodwell, 1998).

The construction of the case report offers you the opportunity to examine civil detainment from various alternative perspectives – including differing perspectives on when and whether civil detainment was necessary and appropriate. The report's documentation of disagreements, over topics such as which criteria met the requirements for civil detainment, is designed to challenge your understanding of the topic and impact the beliefs of individuals involved in the process, such as me, and now yourself. In reading this report, however, you are not to be a passive recipient of information. You have the opportunity to engage with the case story in such an active way that develops a more sophisticated understanding of the multiple perspectives involved in civil detainment. It is expected that you will bring your own unique perspective on the experiences in the case report achieving a greater understanding of the overall civil detainment experience.

Conceptual Model of Thematic Analysis

The major constructs that emerged from my analysis of the data were as follows:

www.manaraa.com

- *The influences that impact* the civil detainment process included: mental illness, mental health services, treatment models, law enforcement, resources of the community, and the values of the individuals involved.
- The individual's *experience of the civil detainment* process included: the logistical aspects of the experience such as transportation and commitment hearings.
- Application of *human rights* included within the civil detainment process: examples of verbal abuse, violations of dignity an examples of promotion of dignity
- The *emotions* that emerged during the civil detainment process included: anger, confusion, and grief
- The *needs for recovery* from the need for a civil detainment included: crisis stabilization units, financial resources, and psychiatric bed availability.

The conceptual model below (Fig. 1) has graphically illustrated the thematic analysis of the data. This illustration demonstrated the precarious balance of different elements that occurred during the civil detainment experience. Each of these elements changed in intensity and proportion depending on the values of the individuals and community involved the geographical location of the experience, and the resources available. The shifting among these constructs had the ability to alter the balance, thus affecting the logistical and emotional experience of the individuals involved.

The analysis of the data found that the identified influences, the application of human rights and the needs for recovery were significant. The two constructs that emerged as a consequence to the three identified earlier involved the experience of civil detainment experience and the resulting emotions.

www.manaraa.com

Figure 2. Conceptual Model

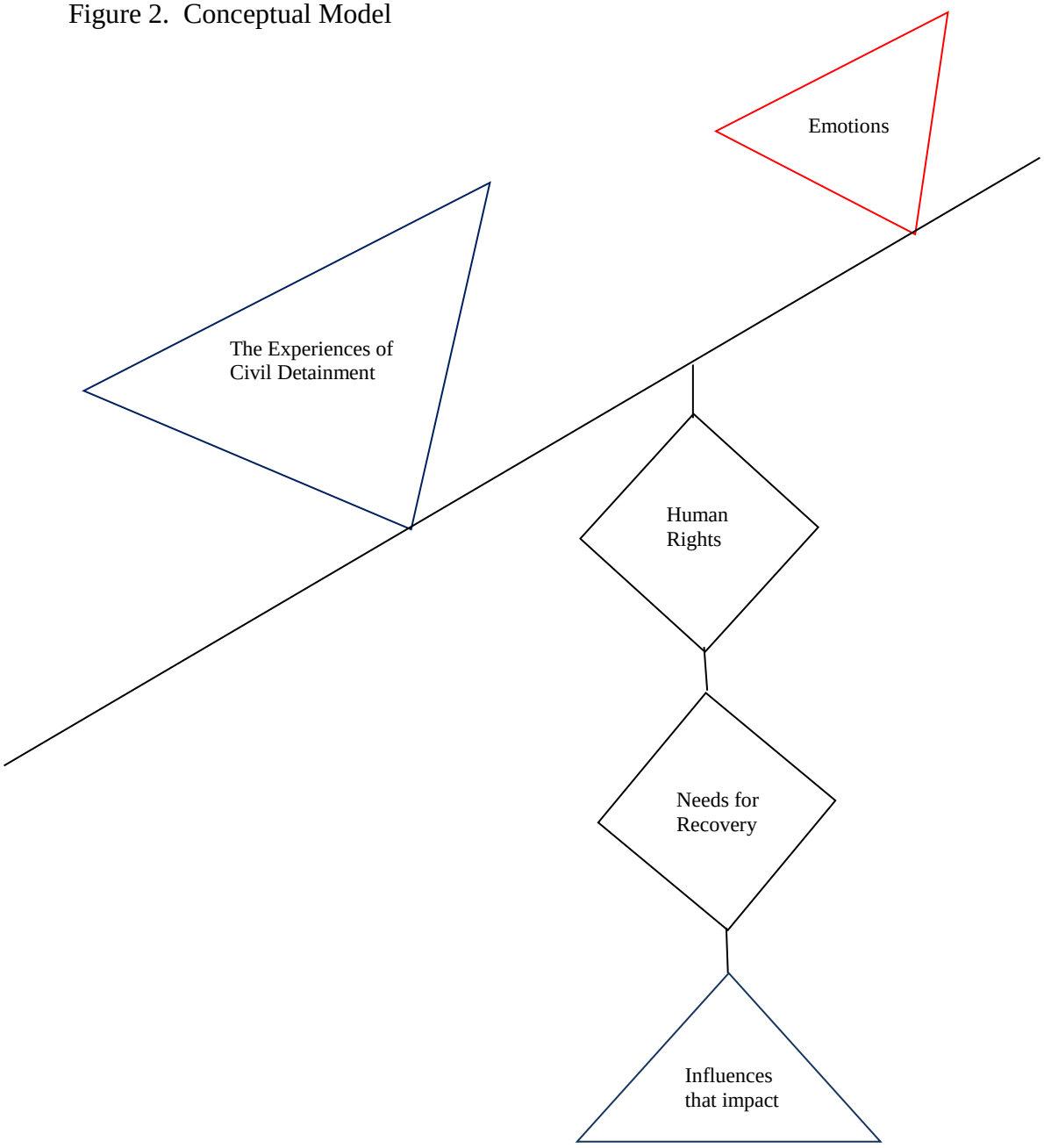


Figure 2 Conceptual Model of Thematic From the analysis, the precarious balance the influences that impact, the needs for recovery, and the application of human rights have on the experience of civil detainment and the resulting emotions became clear.

www.manaraa.com

Directions to the You, the Reader

These directions to you the reader are the same as the directions given to the participants at the final member check. This case story is about the experience of individuals involved in civil detainment. Although the individuals I interviewed represented different groups and various professions, the experiences I described are unique because each individual reacted differently to the circumstances. In order to account for various perspectives, the case report included the voices of individuals with mental illness who were detained as well as the individuals participating in the detainment process (family members, mental health professionals, first responders, and justice professionals).

The case report is written in a manner that uses both distinct and subtle symbolism to represent the nuances of civil detainment. Two examples of the subtle symbolism are the ever-changing weather that proves to be as unpredictable as the mental illness experienced by the individual. The second is the presence of baskets throughout the case report; these symbolize the creative nature that occurs around the phenomenon of civil detainment. Creativity proves necessary in order to weave available resources into a safe container (like a basket) that meet the needs of both individuals with mental illness and the community.

There are thirteen main characters of the story. Each character is a composite of the participants of this inquiry. The characters in this case report are speaking or thinking in ways that reflect the information that I gathered and analyzed during the inquiry. The following table details the characters and the participant groups they represent.

Table 5. The characters of the case report

Primary Characters	Role	Stakeholder group

www.manaraa.com

Ted Randall	Police Officer	First Responder
Henry Johnson	Father	Family
James Henry Johnson	Son	Individual Detained
Lynn Johnson	Mother	Family
DaQuan	Lawyer	Judicial
Judge Smothers	Judge	Judicial
Suzie	Social Worker	Mental Health Professional
Janice	Community Services Board (CSB) evaluator	First Responder
Donna	Sister of Lynn	Individual Detained
Terrance Hall	CSB evaluator	First Responder
Sheriff Hayes	Police Officer	First Responder
Toddi	Donna's Shih Tzu	Family
Sandra Waid	Aid to Congressman	Judicial

Table 5. The characters within the case report, their identified role and the stakeholder group to which they were assigned.

The Meaning of Civil Detainment

The meaning of civil detainment that emerged from this study was one of safety and control. These concepts reflected underlying beliefs about the nature of a mental illness, its ability/inability to be predictable, the interpretation of the law, the conflict over the definition of safety, the range values of the individuals involved, and the distribution of resources. Depending

www.manaraa.com

on the standpoint of the stakeholder, issues of safety shifted in priority and the definition of dangerousness varied as control transferred from one individual to another.

To explain the complexity of the meaning of the experience, I utilized the symbol of the basket. With intricate weaving, baskets have had a long history as symbols of complexity – both within and outside of the mental health community. Basket construction has been a unique and intricate process of weaving that brought together available materials in a creative fashion, with the goal of creating a product that was strong and useful. Likewise, civil detainment has required creativity to weave together resources to produce a strong plan for recovery. With the meaning of civil detainment (safety and control) and the five constructs in mind, the reader is encouraged to examine the aspects of the basket weaving process and consider how it might be analogous to civil detainment.

Traditionally the members of a family group made baskets at home.

Figure 3. Basketweaving 1

Figure 3. Basketweaving 1, “Until the turn of the 20th century, many families made their own baskets. Traditionally, a family would work together on the difficult task of gathering and preparing all the materials needed to weave a basket." (http://www.madehow.com/Volume-4/Basket.html).

www.manaraa.com

Likewise, prior to the creation of asylums, an individual with mental illness was cared for by and within the family (Bachrach, 1980). In this inquiry, the families' care of the individual emerged as a critical component for the establishment of a safe environment – both before civil detainment hearing and after the detainment period. Like basket weaving, the experiences of and the outcome of the civil detainment process was also dependent on the available resources.

The shape and appearance of a basket has been dependent on the available fibers just as the experience of civil detainment has been dependent on the individuals involved and the available infrastructure. As illustrated in Figure 4, the process of any one civil detainment had the potential to be quite complex, and its outcome depended on the weaving together of many resources. The experience of civil detainment was dependent on the availability and use of resources as well as the skill and disposition of the individual who was "weaving the experience".

Figure 4. Basketweaving II

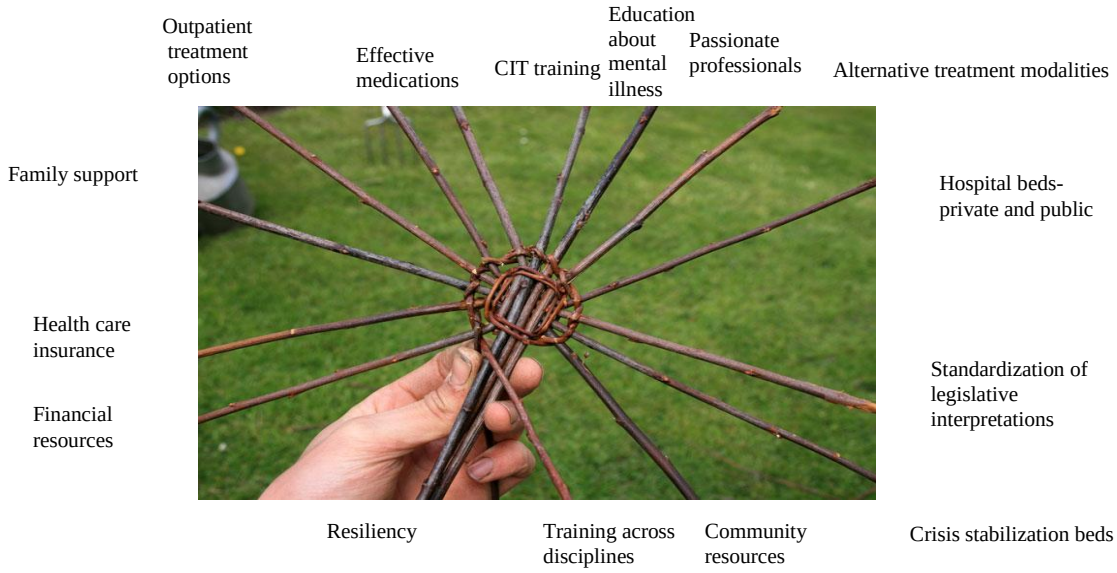


Figure 4 Basketweaving II. "To weave baskets, raw materials are needed such as 'plant fibers including roots, cane, twigs, and grasses; reeds, raffia, and basket willows.' A

www.manaraa.com

basket's character is determined by the material chosen and the technique of the basket weaver as to the size, design, strength, and durability of the basket." (http://www.madehow.com/Volume-4/Basket.html).

Resources have been critical to the effectiveness and security of the civil detainment experiences. Necessary structural resources have included hospitals, community resource facilities, health care insurance plans, medications, and a variety of treatment modalities. Non-structural resources, defined as systems or individuals (Merriam-Webster, 2012), have included mental health professionals, judicial systems, law enforcement staff, and family/support systems. A well-made basket was not possible without the appropriate materials to create it; likewise, a civil detainment experience was not able to take place effectively without appropriate structural and non-structural resources.

Available resources provided opportunities for creative resolutions to the complexity of civil detainment experiences. Lack of resources emerged as a barrier to individuals involved with civil detainment and impacted the level of respect offered to all individuals involved.

Figure 5. Basketweaving III

Figure 5 Basketweaving III. "…the beauty of a basket's weave reveals the weaver's creative vision and technical adeptness at both preparing her materials and manipulating them into a basket form." (http://www.nmai.si.edu/exhibitions/baskets/subpage.cfm?subpage=tech_tech)

During my inquiry, I discovered there was an "art" to the civil detainment process. The art of civil detainment was not immediately noticeable when one examined the separate "parts."

www.manaraa.com

However, if one explored the experience as a whole, a pattern emerged in those civil detainment experiences that were effective and that differentiated them from civil detainment experiences that were less effective. Just as any two baskets (Figure 5) were different in structure, use, and strength, individuals involved with civil detainment had the ability to create different experiences. A civil detainment experience could be designed to meet only the individual's most basic needs such as safety and security. Alternatively, it could be created using multiple resources to produce an experience that maintained dignity and respect for all individuals involved – and beneficial to the detained individual.

Some of the individuals I interviewed described positive experiences during which various participants in the civil detainment process took the time to talk and understand the experience of others and to secure the appropriate treatment resources. This process of individuals taking the time to talk and understand others was interpreted as an acknowledgment of the individual with mental illness as a human being. It was also experienced as supportive of the retention of dignity. The weaving together of both human and non-human resources were both critical to the design of the detainment process and the effectiveness of the care offered to the individual.

Figure 6. Basketweaving IV

www.manaraa.com

Figure 6. Basketweaving IV illustrates quality. "A supervisor may over-see a number of basket weavers and reject imperfect baskets; however, as in the case of most handicrafts, basket weavers take pride in their profession and demonstrate their skills in each product. Even mass-produced baskets are prized for their uniqueness, so some variations are to be expected and treasured." (http://www.madehow.com/Volume-4/Basket.html).

Basket-weaving supervisors examine baskets and reject imperfect baskets at various stages of the creation of the basket, based on particular production criteria. Similarly, there have been a number of individuals with the power to accept or reject a request for a civil detainment order at various stages of the civil detainment process. The initial stakeholder group that may have accepted or rejected a civil detainment procedure has been the police or magistrate. The CSB evaluator and accepting psychiatrist have been second level "supervisors" who also have the power to accept or reject a civil detainment request.

Basket weaving supervisors have attempted to apply uniform standards to their evaluation of a completed basket. Similarly, the "supervisors" in the civil detainment process tried to be uniform in making judgments based on the civil detainment legislation. However, these supervisors encountered numerous obstacles. One of the difficulties in implementing the civil detainment legislation was the considerable confusion about the criteria surrounding the acceptance or rejection of a request for civil detainment. The process of obtaining approval proved, at times, to be challenging and unpredictable for all of the individuals involved. This study found that each individual interpreted the criteria of dangerousness differently, which increased the potential for confusion. Individuals perceived the civil detainment experience from different perspectives, based on varying values and beliefs surrounding mandated treatment. The results were inconsistencies in the policy-in-implementation and the policy-in-experience.

www.manaraa.com

Following is the case report that serves as the findings of a constructivist inquiry. It is an interpretation of the data gathered throughout the entire inquiry process including the word data as well as my experiences throughout the process. It is written in a narrative manner with the intent to illuminate the various nuances that are involved in a civil detainment process.

Case Report

Ted noticed the evening had turned cold and a blustery wind was whipping through the eaves of his cedar home. The Commonwealth of Virginia was a unique state. With five different regions of climate and terrain, central Virginia's weather stations predicted the weather with a roulette wheel. Virginia was a state where you could have rain, snow, and in a matter of hours no precipitation. You could stand at the state's capital and drive three hours in any direction. In three hours, you could be in the capital of the nation, the Atlantic Ocean, the Blue Ridge Mountains, or the Chesapeake Bay. For this reason, Ted had settled somewhere in the middle of the Commonwealth.

The phone rang and the caller id indicated that it was the precinct phone number that his friend and colleague Henry typically used to make calls. Henry lived a different life than Ted. Henry was the IT man for the police station. He was the man to go to when your computer crashed, when you deleted your case report by accident, or when the top dogs sent out a decree that everyone must now carry laptops in squad cars. Yep, Henry got many calls from Ted. Ted was what Henry would call "computer illiterate."

Henry typically worked the day shift due to his family's needs. It was hard sometimes for Ted to hear the stories Henry would share after a weekend off. Did Henry really think he would not be envious to hear about the trips to Wal-Mart with the children, the cost of school supplies, or his daughter's latest boyfriend? He longed for his own stories of family gatherings.

www.manaraa.com

He wanted to have cookouts with the children and their friends and pool parties held for the neighborhood.

"Ted, hey."Henry said over the phone. "I have had quite a day but I wanted to pass onto you some details that I heard around the office before you come back in. I know you are still technically on vacation but I also know how you like to be updated," said Henry. Sure, thought Ted sarcastically, some vacation. More like a 'staycation' as he had stayed home and worked on his garage.

"Great Henry, What do I need to know?" Ted slowly responded.

"It must be a full moon because all the crazies have come out.[1] Johnnie boy called again and said he was suicidal. Of course Bubba had to send the rescue squad out for him. You know the hospital must get so tired of the revolving door with this guy." Laughing he added, "You know what Ted? They now just drive the ambulance up to his back door. Johnnie walks out and gets in the bus's side door." [2]

Ted just shook his head. He knew he would be hearing about this for days from Dottie in the ER. Blah, blah, blah….why do they have to bring them to us….why is it that Johnnie is always cold and hungry….what a waste of resources, she would say.[3]

> *"It is the body language- [others] laughing at them, [the] roll of their eyes..... It [her perception] is not paranoia...just plain truth."* [13]

After a final review of the calls that had come in, Henry and Ted hung up. Ted assured Henry he would come to his next cookout.

Henry. Henry was a small man considered a computer geek. He cherished computers and everyone knew this. He talked in a language only other computer geeks understood. He had grown up in Wayne County and graduated from the local high school. After a brief stint in the

www.manaraa.com

military, he returned to care for his aging parents and joined the local government. His wife had been his high school sweetheart. She had agreed to marry him after their high school graduation. Twenty years later, they had a home on three acres of land. His parents were cared for by people hired to come into the home every day. He was the proud father of three children.

James Henry was his oldest. At age 19, he was in his first semester of college at the state university majoring in engineering. He had graduated from high school summa cum laude and received a full scholarship to play football.[6] Susan, his 17 year old, was the light of his life. She was the spitting image of her grandmother and had the gentleness of her mother. She would be graduating from Wayne County's high school this coming May. She planned to enter nursing school in Richmond. His youngest child was his most worrisome child. Jason, 14, seemed so withdrawn. Jason had always been the one child that just did not fiwith friends or the extended family. Henry and Lynn talked and speculated on what would help him. So far, they had only come up with loving him.

Lynn was the center of his life. Like other couples, they experienced times when they were closer to each other, but overall, they had a good life and had raised three children anyone would be proud of.

It was 5:30 pm and although he had to stay to fill out paperwork, he was glad to be getting home. As he straightened his desk, he looked again at the flyer announcing some new fancy training. Crisis Intervention Team, otherwise known as CIT. Chuckling to himself, he signed Ted up for the "hug a thug" sensitivity training. He placed the signup sheet in the Sergeant's basket on his desk. Ted hated those trainings. A big waste of taxpayers' money is what he would say. [4] Ted could be cynical at times. He needed a wife to soften the edges, Henry thought to himself but a great cop and a good friend.

www.manaraa.com

Pulling up to the house, Henry got out of the car and buttoned up his coat. The temperature was dropping and he wondered if snow would come. He entered the house through the garage as he did every night and came through the door on the side of the house leading directly into the kitchen. Lynn would be at the stove finishing dinner and he would give her his "glad-I-am home kiss."

He opened the door and was surprised to see Lynn sitting at the kitchen table with the phone in her hand. The Kleenex was in front of her. She was hanging up the phone and remained sitting looking worried.

"Is it Jason?" he asked with a furrowed brow.

"No, James Henry," she answered.

"What's wrong?" he replied.

She hesitated and then said, "I don't really know. He doesn't sound right. I asked him how classes were going and he said fine but….I don't know.[5] Something just doesn't seem right. He said that he hasn't been sleeping and his voice didn't sound like he was happy. I told him to hang in there. Maybe it is him being away for the first time. I assured him that he would be coming home in three weeks. Do you think we should get him to the doctor?" [9]

Lynn was such a worrywart at times. "No, honey, I am sure it is being away from home. If he is still having trouble when he gets home in a couple of weeks, we will get Dr. Wyatt to check him out". Henry sat down beside her and placed his arm around her shoulders in a gesture of support.

Dottie. At the local emergency room, six o'clock could not have come fast enough for Dottie. She was finishing her shift in the ER and glad to be going home. Sometimes the ER was quiet but today it was busy and she had trouble getting all of her paperwork done. There were

www.manaraa.com

two stabbings, a woman wanting Xanax for anxiety and two children with the flu. Oh yes, there was also that guy who comes in for a "break." He says he is suicidal but she knew he was faking. Why else would he come in only when it was either very hot or very cold? [7]

Going home, she was ready for a long stay in the bed. After being in the ER for 12 hours for the last three days, she deserved a break. Maybe she would call Bubba and ask if he would send the rescue squad for her. She could go to a hospital for a break, like Johnnie. What a joke!

She had left him in a room with dinner ordered and covered in blankets. He would probably stay until the morning. Then be discharged after he had been seen by the hospital psychiatric staff and the community service board emergency services staff. She had treated two people "bleeding out" and two children under six with 104 temperatures and dehydrated. People seeking medication for anxiety or Johnnie needing a warm bed and a meal were not a high priority for her. Keeping people alive was her job, not coddling basket cases.[8]

DaQuan. The snow had not come and yet the clouds hung low over the city. It would snow before the day was over. DaQuan did not care what Craig Arbry, the local weatherman, said. He had grown up in Ohio and knew what the clouds were trying to tell us. Snow was coming and more than a light dusting.

He parked his car in the allotted parking deck and made his way in to the professional building. Being a lawyer was all he had ever wanted to do. He had worked hard to pass the bar exam. Virginia's was known to be one of the hardest to master. He tried not to show his ego but his associate status with McMiller & McMiller was a coup. Not many young lawyers could brag about acquiring such a prestigious job so early in a career. He knew that it was partly due to his mentor Judge Wyatt. He had also worked hard to fit in.

www.manaraa.com

On his desk was his itinerary for the week. It looked like it would be a full week of depositions, hearings, and meetings. Signing in, he told the secretary he was off to the hospital for the scheduled commitment hearings. Billing was an important part of the job as it produced money for the practice and a salary for him. Recently, he had been acting in several roles in regards to civil commitment hearings. He had been the assigned lawyer for the individual who was being detained as well as a judge in the hearings. [19]

He preferred the role of judge. As a judge, he had more control over the length of each hearing. If it was a good day, he would be able to complete three hearings in 30 minutes. He would produce $86.25 per hearing as well as $43.25 for a certification hearing. It would mean a total of $126.50. This could potentially produce over $700 an hour. Not bad for an associate lawyer, he thought smiling to himself.

As a lawyer assigned to the individual who has a mental illness, he was at the mercy of the judge as to how many hearings were completed. As a lawyer at $75 a hearing, he had the potential to make a significantly smaller amount. For the same amount of time and twice the work as the appointed counsel, he would only make $450 an hour. Today he was the lawyer. Oh well, he never found this job boring and would enjoy the day nonetheless.[10]

The psychiatric hospital that DaQuan entered was established in the late 1900's. The certificate of need (CON) was approved for 114 beds. The administration had decided to designate 14 beds for children, 20 for adolescents, 55 residential adolescent beds, and 45 beds for adults. When the census was high, between 100 and114 patients, the hospital was able to run efficiently. Depending on the payor source, if the census dropped below 80, staff would be laid off. It was a delicate balance for psychiatric hospitals. There was less profit to be made as

www.manaraa.com

compared to a medical surgical hospital offering specialty treatment such as heart catheralizations.[11]

DaQuan entered the hospital, speaking to the receptionist. "Good morning, Sally."

"DaQuan, you are going to have a busy day today. Did you notice? A full moon last night and our census jumped from 101 to 111. Everyone was hopping last night, especially the acute unit. Eight TDO admissions is almost a record!" It still seemed strange to him that such pleasure could be felt at the expense of someone else's mental health .[12]

DaQuan smiled and nodded as he waited to be let into the main part of the hospital. The doors to the unit were locked. Everyone had to be "buzzed" into the main section of the hospital. The sound startled him as it did each time. It reminded him of the sound of the buzzer as the doors to the jail hallways were opened. He wondered sometimes who the locked doors were protecting, the staff or the patients.[14]

Making his way down the hallway to the acute unit, he could see the various offices. The staff members were working full steam at 8 am. There was a smell to a psychiatric hospital. It was different from a regular hospital or a nursing home. It was more the smell of nothing, in the administration's attempt to disguise the building as a mental hospital.

Approaching the unit, he hit a button that allowed him through the next set of doors. The camera mounted on the wall allowed staff to monitor everyone who came in as well as all of the patients' congregating areas on the unit. Once on the unit, the metal doors clicked shut and he moved into the nurse's station saying hello to the staff. The patients were already moving about on the unit.

If you were intuitive, you would be able to feel the anger that swirled around the patients who had been brought to the hospital against their will. Some patients would be waiting for

www.manaraa.com

medications to be dispensed. Others moved around agitated in an attempt to avoid the effects of their two packs a day habit being cut short by the click of that metal door.[15]

DaQuan walked up to the secretary. "Hey, Martha. How many do I have today and who is the judge for us?"

Martha was the person who knew everything. She listened in on conversations, monitored the admissions/discharges and could tell you the history and the gossip on the psychiatrist that was the attending on any given day. "Whew, we had eight TDO's last night and five the day before. You will be with Judge Wyatt. He has already called in and has secured the room from 9 to 12. It seems he wants to get all of them done." [16]

Thirteen hearings would be a productive day. This would mean he would have to hustle. Thirteen was certainly doable and he may be out of there by 11:00, if he was lucky. He had once completed six hearings in one hour. That was with Judge Smothers. Given that the judge TDO'd everyone, the paperwork could really be completed in advance of the hearing. He hoped all parties would be able to arrive on time. It appeared from the paperwork there was one member of a CSB that was driving one hour for the hearing. [17]

"Okay Martha, let me review the charts. Tell me when Wyatt gets here."

"Sure," she responded.

Eleven o'clock found DaQuan walking out of the unit and down the hallway. He wondered if he would be able to grab a quick bite before he got back to the office. As he sat at Panera Cafe, he thought about how his job was both interesting and complex. Today, there was a woman who had been TDO'd. She was obviously pregnant but due to her mental illness, she refused to accept she was seven months pregnant. She had not followed up with any prenatal care. She was agitated and stating that she was hearing God tell her all medications were poison

www.manaraa.com

and that she must watch out for the government. She believed the government was monitoring her every move. She was delusional and psychotic. The doctor was asking for anti-psychotic medications to help stabilize her illness but her family was refusing on the basis there would be side effects to the fetus.

He knew in the Commonwealth of Virginia, a fetus was not a separate individual and so the decision to force medications was not a battle for the safety of the child. It was about the safety of the woman. For this reason, the medications would eventually be given. DaQuan finished his early lunch contemplating the ethical dilemma that had risen. He wondered if it would be argued in court or resolved some other way.

What are the ethics of doing six commitment hearings in an hour? Did it jeopardize an individual's civil rights for financial gain? Are there ethics in completing a hearing at the side of the patient's bed? Were the rights of the individual protected if he was admitted at 4 am and his hearing was scheduled at 10 am due to the need to complete the hearings within predetermined time frames? Is it ok to skip over a full reading of the patient's rights due to the impression that the patient was not cognizant of what would be occurring?

He had been told of one county where the lawyer representing the CSB also represented the individual detained. Some would say this was double dipping. Would that constitute a conflict of interest or is it just a matter of necessity given the lack of resources? [18] Contemplating the new civil commitment legislation policy's intent versus implementation was overwhelming. He was aware of the dilemmas resulting from all the conflicting demands.[19]

After getting into his car, he realized he had left without grabbing his briefcase. He smirked at his mental preoccupation about ethics and returned to get his bag. With the rest of the day ahead of him, he knew he could not give ethical issues any more thought. He decided to

www.manaraa.com

focus his attention on the weather as a way to divert his thoughts. Snow had begun to fall as he predicted.

Lynn. There had been an accumulation of nine inches of snow. The city had slowed as Virginia's snow removal team was not practiced. With the continued low temperatures, it would be weeks before it would begin to melt and change from white to black grit created when chemicals are placed on streets and traffic continuously grinds it into the wet melting snow.

It didn't matter to Lynn. James Henry was coming home. She had been on the phone with him every day and evening. For the last seven days she tried to help him hold on until he was able to finish classes and get a ride home. Scared? She did not think that came close to describing the terror that seemed to be smoldering deep inside. She knew her son. Something was wrong! [20]

Lynn stood at the bay window watching for the Honda that would deliver her first-born back to her. She told herself once he was home, she would feed him and get him to bed. An appointment had been made for noon tomorrow with their family doctor. She knew he would help. He had followed James Henry since he was born. Maybe because he was almost 60, Lynn trusted him explicitly.

Her mind drifted to the past as she stood waiting. Something seemed familiar about what James Henry was telling her but she could not put her finger on it. Maybe it was an old nightmare or an old memory. Over the last three weeks, she had tried to figure it out and talked about it so much with her friends that she noticed some were not calling her anymore.[21] Oh well, she thought, her true friends were still with her. Henry was still willing to listen even though she knew he considered her an excessive worrier.

www.manaraa.com

The blue Honda turned into the wide driveway and Lynn ran out smiling broadly and calling to him. "James, it is so good to have you home. Can I help with your bags? Did you guys eat on the way down? Do you want your friends to come in?" James Henry looked tired, she thought, but why shouldn't he? The drive was almost four hours and driving in the snow made it even longer.

"No Mom, I just want to get in the house. See you guys." With just those two statements, James Henry grabbed his bags and walked into the house.

James Henry. The house seemed different to him. It could have been that he had been gone for three months but something seemed wrong with the house. Maybe his mother had changed the furniture around. She seemed to do that every three months. He hoped his bedroom was still in the same place.[22]

He turned and went up to his room and lay down on his bed. It was only five minutes before he was snoring, a sign of a deep sleep. He was unaware of his mother who placed her hand on her heart unconsciously while she watched her son spread out on his childhood bed. He needed sleep. Surely, that was his problem, she thought.[23]

A few weeks later, back at the dorm, the hallway was pitch black but the noise was loud. James Henry was so tired from not sleeping for several nights that he might as well get up and work on his paper due to Professor Conway. He thought she was nice but lately he could tell she was going through something. She was meaner and had failed him on the last paper. Since returning from the fall break a month ago, he had yet to figure out why she was against him. He was going to work hard on this final paper and pull his grade up. [23]

Later that day, he showed up for his appointment with Suzie at the counseling center. He did not really see the point of therapy. [24] He did it so his mom would not worry so much. Talk

www.manaraa.com

therapy, what was it really going to accomplish? He needed his grades higher and Professor Conway off his back.

"Come in James Henry. How are you this week?"

Sitting down in front of Suzie, he noticed she was watching him more intently than usual. "Fine," he replied cautiously.

"Good, well tell me what you want to talk about this week. How are things going with Professor Conway?" Suzie inquired.

James Henry could hear it, the whir of the tape recorder in the covered basket in the corner of her office. [25] He was getting tired of his sessions being recorded and began to wonder if the Professor had asked Suzie do this. "It's ok. She is great. I am trying hard and I am sure that this last paper will demonstrate that."

Smiling inside, he felt satisfied the answer he had just given would satisfy Professor Conway. She would most definitely be listening to the tape. She would give him an A on the paper after a few more compliments aimed at the tape recorder.

"Great!aAnd sleeping? How is that going?" she asked.

"I don't know. The noise in the hallway keeps me up all night. I find that the best way to handle it is to get up and work on my papers." [26]

Suzie. Suzie seemed perplexed, "Noise? What kind of noise. If there are people partying, then you could talk to your resident advisor (RA) and get him to quiet it down." She wondered if he was having a more severe mental health issue than she realized.

Wondering to herself, she assessed the need for hospitalization. She had been meeting with James Henry for several weeks. She had begun to notice a steady decline in his ability to think clearly, make sound judgments and maintain relationships. She had verbally approached

www.manaraa.com

him with the idea of admitting himself to a hospital but he had adamantly refused. Was a TDO needed? [27]

The last time, her request for a TDO was denied in spite of her knowing her client longer than the CSB evaluator. The trauma of the police arriving to detain, the use of handcuffs, and the betrayal in her client's eyes could make treatment afterwards more difficult. The result of that denial was her client had gone home and shot herself the next day. She could feel her own anxiety increase at the dilemma before her. Should she have him assessed against his will and possibly risk another loss? [75] She needed a plan of support for him and a way to ensure she had protected herself from any issues of liability , she thought to herself. [27]

"Talking, incessantly!" James Henry appeared more agitated. "I go out to find out who is doing it but they must hear me coming. They run back into their rooms before I can catch them. It gets quiet for a while. Then by the time I lay down again, they are outside of my door again, talking and laughing. I get so tired of it" [28]

Suzie was taking notes and he could still hear the quiet whir of the tape recorder. In a quiet and somewhat hesitant voice Suzie asked, "James Henry, I know Christmas break is coming up. Would you consider talking with your doctor about all of this? He may be able to give you something to help you with the sleeping." [27]

James Henry thought for a minute. One more person who was trying to control him! He did not share his thoughts aloud because then she would probably think that he was really crazy. "Sure, but my Mom had me see my regular doc the last time I was home. He said everything was ok. So what could he do for me now?" [24]

"Well how about seeing a different doctor who specializes in issues like this, sleeping and all. I have a few names of psychiatrists in your area that would be willing to talk with you."

www.manaraa.com

James Henry began to frown. Yep, she thought he was certifiable. Great, crazy, that was all he needed to add to his resume. [87] Maybe Dr. Conway had gotten to her. Maybe his Dad had called. Shifting his eyes around the room, he contemplated how he was going to handle this twist.

After some thought and consideration of the possible outcomes, he said, "Ok Suzie but I don't want you to talk to my parents about this. I know you have probably talked with my Dad but I don't want them to know about it, ok?"

Suzie replied, "Sure, can I call and get you an appointment?"

James Henry knew that she was like a dog with a bone and would not stop until he agreed. He said yes. Trying not to appear too angry, he sat there while she called one doctor after another until she secured an appointment. Suzie hated this part of her job. It had gotten incredibly hard lately. Particularly finding a good psychiatrist who was willing to accept particular insurances and had openings on short notice was hard. [6] Most appointments were two months out. Finally, she was able to connect with a doctor who had opened up some slots just after Christmas.

"Ok, James Henry, I could get an appointment with Dr. Charles for December 27th. So you will go?" she asked.

Geez, get off my back he thought to himself. He was not having a nervous breakdown. It was just that everyone was watching him and trying to control his every move. Who wouldn't be having trouble sleeping? "Sure," he replied.

Finally out of the office, James Henry walked back to his dorm by the buildings on the left. He had come to know that if one walks close to the buildings on the left, no one could

www.manaraa.com

follow you or monitor your thoughts. [28] Suzie stood at the office window watching him leave and wondering if James Henry would keep that appointment with the psychiatrist.

Lynn. The call came into the police dispatcher. Lynn had called 911. James Henry had barricaded himself in his room. He was screaming that they were out to hurt him and for everyone to stay away. Christmas had gone relatively well. Her family had come in and they celebrated Christmas Eve. Jason and Susan seemed to enjoy themselves but everyone else seemed to stay away from James Henry. Or was it that James Henry had stayed away from everyone else? It was hard to know. He had been home three weeks and his behaviors escalated every couple of days. He was scary now. Henry had begun to lock their bedroom door at night, just in case.[29]

Lynn had tried to reach out to her friends but they had begun to say she and Henry needed to "wash their hands of him" or "give him tough love." [89] They did not understand what was going on. She had also begun to isolate herself because they were recommending she abandon her son. She did not know why this was happening to them.[90] How could anyone desert their child? She couldn't, she wouldn't! "911, what is your emergency?"

"Our son is in his room upstairs and has barricaded the door. He is screaming that we are out to hurt him. He is not making sense. We need help, *please.*" Lynn pleaded.

The dispatcher began to ask questions in a slow, what was supposed to be a calming voice, "Does he have any weapons? Has he hurt anyone?"[14]

Lynn became increasingly frustrated as she answered the questions, waiting for the dispatcher to understand the situation and respond with help. It seemed like hours before the police were dispatched and then arrived at the home.

www.manaraa.com

When the police pulled up in the driveway, Henry was glad to see it was Officer Ted Randall. Coming into the house, he asked where James Henry was. He also asked if there were any weapons in the house. He then made his way up the stairs to the room talking to James Henry the entire way.

Ted talked for a while with both parents in the hallway while also trying to calm James Henry, who was still behind a locked door. It seemed they were scared of their son. Maybe because they were getting older. Maybe they are the type of parents who are so controlling that the son was rebelling. Maybe they were all crazy. After an hour and a half of talking including a discussion with his partner, Dan, Ted made the decision to take James Henry to be evaluated by the CSB staff.[30]

Ted and his partner told James Henry he needed to come out or they would have to come in. With deliberate coaxing for over an hour, the door opened and both officers went in. They quickly handcuffed James Henry. At that point, James Henry began to scream again at his parents that they did not love him and they were just trying to get rid of him. [31]

> *"I see it in the cops' eyes. They are stand-offish trying to figure out what is going on versus who I am."* [32]

Henry began to say to James Henry, "Calm down. They are trying to help."

Officer Ted intervened, "Henry, please step back. We have him and will take him to the CSB who will evaluate him. Please step back."

> *"If the police will say he needs to go*[be civilly detained]*, then things will move very quickly."*[33]

Henry and Lynn backed away and watched with a look of helplessness at the series of events that were playing out.[29] Their first born was being handcuffed and taken out of the house

www.manaraa.com

to be put in the back of a squad car. Four police cars were in the front of the house with blue lights flashing. The neighbors were watching from the windows and porches. It was heart-breaking [103] to have him taken away and scary. He was 19, considered an adult and if something happened, he could end up in jail with adults. Lynn knew she would not be able to handle that; nor would he.

> *"The system would rather him commit a crime and put him in jail….. I have a small boy that is going to the big boy jail. That will end my life. After all this time of my trying…I will not go past that day. The law will take him to jail but mental health will not let him into the hospital…and yet he is reacting to things that are not normal and so will commit a crime.*[34]

As the police drove off with James Henry, both parents could hear him screaming that he would get them. It tore their hearts in two. The only bright light was that Jason and Susan had gone with their grandparents for the week. How would they ever explain to them that their brother had been taken away in handcuffs? [35]

Later at the Community Service Board Office, "Excuse me, I am Mr. Johnson. I am here to talk with you about my son James Henry. He was brought in by the police about 15 minutes ago" Henry anxiously said to the intake staff at the emergency services office of the CSB.

She looked up from her paperwork and directed him to the row of chairs against the wall. "If you will wait over there, someone will come out and talk with you."

"Thank you" he replied as he made his way over to the chairs indicated. As he sat and waited, he could almost feel his heart pounding in his chest. He feared what would happen next. What *was* happening, though? Henry thought back to James Henry as a baby and then as a young man. All seemed right. What had gone wrong? [35] Maybe he was taking drugs? Had someone laced something that he had taken? Henry wondered what he had done wrong. With so many questions running through his head, after an hour and half, he felt like he needed to lay his

www.manaraa.com

head down. It was so full with questions and no answers. When would someone come out and talk with him? [36]

Finally, a young woman came out calling his name. "Mr. Johnson, my name is Janice Smith and I have evaluated your son. He appears to have settled down. It is my opinion that he does not meet the criteria for admission to a psychiatric hospital. Is there any information you want to share?" inquired Janice, the emergency services staff person for the CSB.[36]

Henry began to share the history of James Henry and all that had been going on since he went to college. She took notes and afterwards indicated she would return in a few minutes. While waiting, his wife Lynn walked in, crying and obviously shaken and distraught.[75]

"Henry, what is going on?" she asked.

"Honey, I don't know. This woman, Janice came out and talked with me about what was going on. I have not seen James Henry but she is deciding if he needs to be hospitalized." He said.

"Hospitalized? Oh Henry, what has happened that we're here?"

Henry shook his head because he had no answers for her. Just at that moment, Janice returned and introduced herself to Lynn. "Mr. and Mrs. Johnson, I have evaluated James Henry. I do not think he meets criteria for inpatient care. He is telling me he is not suicidal or homicidal. From what you are saying, he has not attempted to harm himself. He has no weapons. When I questioned him about the threats to both of you, he stated he would not hurt anyone."[37]

Henry sat forward and said, "So what do we do? He has been getting more and more paranoid. He is not sleeping and barricades himself in his room for days."[28]

www.manaraa.com

Janice looked compassionate.[79] This was difficult for her[75] because she could tell the family was in need. Given the new legislation, James Henry was not meeting criteria. "Mr. Johnson, if he is not willing to get help, we are unable to force him. At this point, we cannot proceed with a temporary detainment order. He does not meet enough of criteria listed."

"We are mandated to be the least restrictive." [38]

Lynn was able to see the clipboard Janice had and saw the checklist she had referenced. "How many check marks does it take before we can get him help?" she asked sarcastically.

Janice explained the individual needed to be threatening suicide, homicide or was unable to care for himself to the degree that he is in danger. She had utilized this script so many times she could say it in her sleep. "Because he does not meet those criteria, we have released him." [39]

> *"We don't always get the right information. If we get there and they are not presenting as dangerous then we have a criteria sheet to look at. Everybody is going to interpret it differently. That's the problem, some workers are unsure of the definition of danger or near future."* [39]

Henry and Lynn left shaken that so much had happened. No help had been offered. What services were out there for mental health needs? When they got back home, they found the front door ajar. James Henry had returned and destroyed the home. Items were broken, windows had been smashed and upon inspection of the entire house,James Henry was nowhere to be found.[14] What now?

If they contacted the police, James Henry could go to jail with criminals that were far more dangerous. [40] They could not do that to him…..but what about their own safety? Who would protect them? Was James Henry safe driving a vehicle? Were other people also on the road safe? It was one a.m. in the morning. Henry and Lynn sat in their living room stunned with

www.manaraa.com

the cold winter wind blowing through the picture window that had been shattered by the chair now laying in the front lawn.[41]

"It is like a death in the family that no one gets to mourn."[34]

Ted. It was the middle of February and the weather had become warmer. The trees appeared confused as the buds were beginning to pop. The daffodils were beginning to show up in sunny areas. That was the nice thing about living in Virginia. If you wait long enough, the weather will change. Weather was never boring for long here. Ted smiled at his thoughts about Virginia. There were songs that spoke of the smell of Virginia and the history of the Commonwealth. It was a great place to live with all its history and diversity.

Ted's extended family resided in varying places across the state. When they all congregated, discussions were lively about the uniqueness of each of their homes. Each county, city, and town provided citizens with their own unique challenges and advantages. In the rural areas, resources were few and spread apart. His friends in the police departments in rural areas shared how trips to "calls" sometimes took an hour to accomplish. This at times hindered their efforts to help but it came with the territory of rural Virginia.[42]

A call came in on his cell phone. Ted saw it was Henry. He was calling later than usual. "Hey Henry, what's up?"

"Ted, I need your help." Henry sounded shaken and was evidently beside himself.

What was happening? "Sure Henry, what can I do?" replied Ted.

"It is Donna, my wife's sister. She lives in Sandford, on the edge of Virginia. We received a call from a physician in their emergency room. She tried to kill herself. [14] They are telling me she took an overdose of pills and her son found her. He is only 14 but he called the rescue squad. They came and have taken her to the local hospital." [43]

www.manaraa.com

Ted asked, "Henry, what can I do. Is this the first time?"

"No", said Henry. "She has overdosed in the past and has a history of depression. I never told you because…well…..how do you tell someone that your family is crazy? [44] We don't typically get involved because she has done this so many times. We thought she was just trying to get attention but with all that has happened with James Henry, we have learned that this is a true medical illness. She has not worked for five years and has no medical insurance. She had been going to see a doctor in her area for medications but they seem to have stopped working. The new medications the doctor recommended cost $*600* a month for *just one* medication! So she stopped taking them. What is she supposed to do?" [45]

> *"I was not 'in the system' and until then it was so hard to get help. Once you are in the system, help is available."*[46]

"Gosh Henry, I don't know what to say. I never realized the cost of medicines was so horrendous. What is the hospital saying?" Ted asked.

Henry then went on to say, "The hospital is stating they need a family member to pick her up and take care of her. I think they don't want to admit her because she has no insurance or monies to pay her bill. We can't take care of her. She can't go on our insurance. With my schedule at work, her care would fall on Lynn." [45]

"Henry, I am at a loss. I will help anyway I can." Ted had been worrying about Henry for the last year. He had stopped golfing, seemed tired and more irritable.[103] Ted had spoken with Lynn about his concerns. She also seemed overwhelmed and very down in the dumps. He had heard rumors they continued to have trouble with James Henry. Henry had not talked with him about it. Ted thought it best to respect Henry's privacy and did not pry into their business.

www.manaraa.com

"Ted, do you have any connections with people in mental health? I know you took that training, CIT. What was that about? I know it was about handling people with mental illness. Can you help?"

Ted thought about his connections. Terrance came to mind. He was a social worker in the CSB's emergency services and tended to look at each case thoroughly. "Henry, let me make a few calls and I will call you back with what I find. Call the hospital and ask how long they can hold her before discharge. That way we will know how much time we have to work with to gather resources and make a plan." [47]

> *"I* [individual detained] *am grateful for mental health services. My oldest daughter committed suicide and I have had a lot of losses which trigged my issues."* [48]

"Thanks Ted. You are a lifesaver." Henry's voice sounded tired but somewhat relieved as he hung up.

Ted got off the phone and mentally shifted through his internal rolodex of people he knew. Several years ago, he had an occasion to be in Sandford doing some work. He had met Terrance Hall at the local CSB. This was definitely a "local" CSB as the area was rural. There was only one CSB with three workers who all lived in the area. The one Sherriff and deputy had been elected into the office for the last six terms. It was a friendly enough place but everyone seemed to know everyone else's business. After the job was finished Ted had left the small town to return to an urban area where one could be more inconspicuous. In the urban area, people did not know your habits of shopping at the local Wal-Mart or which coffee house you frequented. He guessed anonymity could be a blessing or a curse. In a small community, people seemed to come together to help each other out.[49]

www.manaraa.com

After searching through his stack of business cards, he realized he did not have Terrance Hall's number. He decided to contact the local Sheriff to locate a direct line. The phone rang twice and a man's voice answered, "Sandford police, how can I help you?"

Ted identified himself and asked for Sherriff Hayes. "One moment and I will put you through." The voice replied. It was only a moment before Sherriff Hayes, otherwise known as Chick picked up the phone.

"Ted, hey how are you over there? What has it been, two years?" Chick said.

"Yes and I am sorry to bother you with an emergency but I have a friend whose sister-in-law is in your ER. I need to contact Terrance Hall who used to work at the CSB office. I am unsure if he is there. I don't have a number and thought you may have it." Ted waited for no more than a second when Chick replied, "Sure, Terry is over at the office now. I just passed him coming back from lunch. Now if you call the office you may not get him because the secretary, Alice, is out with the flu. Here is his cell phone number, 555-9869."

"Thanks Chick", Ted relied "I will give you a call in a couple of days and maybe we can catch up."

Hanging up, Ted dialed Terry's cell phone and immediately got Terrance. "Terry Hall,"a voice identified himself.

"Hi, Terry, my name is Ted Randall. We met a couple of years ago when I was down your way on special assignment."

"Sure Ted, I remember. What can I do for you?" he asked.

Ted explained the situation as best as he could. He had learned quite a bit from the CIT training, a volunteer opportunity where he had not *really* volunteered. Afterwards he was glad he attended. As a result Ted was able to share with Terry, Donna's depression in the language of

www.manaraa.com

the "mental health world" not the legal world.[4] Terry knew about Donna from a call by the CSB that was managing the case. Although he had not been called, he said he would follow up with Ben, the ER MD to find out what was happening. Ted thanked him. Hanging up, he placed a call to Henry.

> *"I am the cop who has mental health training. I can use the [mental health] language and turn it to the cops' language."*[50]

Henry. "Thank you, Ted for the information." Henry was relieved to have his friend on the case helping.

"It has been a hard year," continued Henry. "Lynn has been having trouble herself with depression. We have been trying to find a medication that will help her. Luckily we have insurance but it is still a "hit or miss" with all of the side effects, etc." [51]

This was the first time Henry had opened up about what was happening in his life. Ted did not want to intrude or probe too much. "I am sorry Henry. I didn't know…is there something I can do for you?"

Henry exhaled a long, tired sigh. "No, it is just so few of our friends and family understand mental illness that after a while, you just stop trying to make them understand. Besides, they all have their own life and who wants to hear my family's struggles over and over again. You know our oldest has been giving us a run for our money. We just got a diagnosis from a really good psychiatrist out of Thomasville. But the stress we have been under, trying to find him the right care, getting him to agree to go and then take the medications has just been…" He trailed off. Why was he sharing this with Ted, he wondered. Now it would be all over the office [52] and everyone would think he was crazy, or responsible for James Henry's illness. In addition, now he has told Ted about Lynn and her sister.

www.manaraa.com

Ted could tell from the tone in his friend's voice it was hard to talk about. "I'm sorry Henry. I can't imagine how hard it has been. I wish I had known."

Henry paused, thought for a moment and decided to take the risk, "I don't want it around the office as there is still so much stigma and misunderstanding about mental illness.[52] I guess I had enough to deal with in my own home. Work became a place where I could get some distance from it…..sort of. I guess you noticed that I have put on a few pounds…ok, ok," and chuckling for the first time, "20 to be exact and now I am taking high blood pressure medications. With a mental illness, the whole family is affected. We have lost friends. My family doesn't want to be around us and my other two children stay away as much as possible."[21/53/75]

Ted thought about all he had learned. He had not known what Henry was dealing with and tried to reassure Henry the information would stay between them. He also attempted to assure Henry that if there was anything he could do to help, he had only to ask. He ended the call reassuring Henry he would call as soon as he heard something from Terry.

Donna. Donna felt humiliated and angry.[54] Here she was again in the ER. She had just wanted to end her life and stop being a burden on her family, the few she had left. She had lost her son years ago after the first psychiatric hospitalization. She remembered the first time she was detained. The fear was so immense she could not remember the entire process. What she could remember were the large men who stood around her "escorting her" to the locked unit and the click of the door as it locked behind them. Donna noticed her palms becoming clammy as she thought back to that time. [55]

www.manaraa.com

Her husband fought for a divorce and sole custody with the only argument being that she was "crazy." That one hospitalization seemed to be enough to persuade the judge that she was dangerous. So she lost custody of her son. No other reason, just a mental health history.[53]

> *"When I tried to visit [my children], I found that they were scared to even let me hold them or see them. We went to court for divorce and custody. You can't get away from mental illness; it is constant foreshadowing if there is a mental illness."* [53]

It made so much sense to die. No one would have to worry about her anymore. It would take some time to get over it but they would all move on with living. She would become just a distant memory. Failing again with the overdose now meant she would have to contend with a gaggle of people asking a ton of questions that was really none on their business, in her opinion.[56]

She knew the drill. She had been TDO'd eight times over the last 15 years and 6 of those times she had been forced to stay in the hospital. None of them had been in this town but still, it would be the same. Everyone would find out. HIPAA seemed a joke these days especially with those damn electronic medical records. [79] With a push of a button, her whole life would be displayed on some computer screen in the doctor's office. She would begin to get "the look."[57]

She called it "the look" because there was nothing ever said when someone knew about your mental illness. The look came with a slight rolling of the eye, a dismissive condescending turn of the head, and a smirk that was subtle but still present. She had found most people did not have to know about your illness. But if it meant you had been hospitalized eight times, well, they were probably going to find out anyway so it was best to tell them.[52] The doctor would change his tone of voice. The nurse would probably back off from her. But the worse was in her day to day life, like trying to date. When it came time to telling your date you have a history of

www.manaraa.com

mental illness and hospitalization…it was a guaranteed relationship killer.[58] Her longest stay in a mental hospital was 25 days.

> *"You have to be strong to survive detainment. Time slows down when you are in there. The first two weeks, you are able to manage but then after that it begins to get to you. The isolation and the sense of being forgotten."* [59]

Suddenly she was hit with a sinking feeling. What would happen to Toddi? She had always wanted a Shih-Tzu and had found Toddi one year ago in a newspaper advertisement. She had no one to care for her. What was she thinking when she took the pills? She was such a loser. She had not even thought about Toddi.[54] It troubled her. She had gone so far down, she had forgotten the only one who had needed her, Toddi.

Sighing to herself and closing her eyes, she imagined the next steps. Someone would come from the CSB and talk with her. He/she would ask her the questions they always ask. Questions like, are you suicidal? Are you thinking about hurting anyone else? Do you hear voices? Nope, no voices…..she would never tell them that. Then they would lock her up and throw away the key, for sure. Especially if they knew the answer to that question![1]

She would have to wait in the ER probably a couple of hours while the CSB worker completed paperwork. Depending on where there was a bed, she would be sent to a hospital to be searched and locked on a unit.

> *"There are times when we [first responders] call 13 hospitals and can't find a bed so we leave them [the individual] in the emergency room where they are medicated and left and then sent back home. If it [looking for a bed] happens on a Friday night, we are in trouble."* [11]

Then the judge would decide whether she could go or had to stay.[25] She wondered if any of them would know that once she had been a manager of a large shoe store. Would they know that she could add five sets of numbers in her head and that she loved pickles. No, probably not.

www.manaraa.com

The worker would only know she was a "thick chart" full of previous hospitalizations and multiple diagnoses from the many doctors she had seen.[60]

I wish, she thought to herself, someone would take time to just sit down beside me. Offer me something to drink and ask me to tell them about myself.[66] She was not a chart or a basket case! She was a human being and all she wanted was the basics. To be treated like a human with feelings and thoughts. A human being with dreams who once was a manager of a busy store with two employees she was responsible for.[60]

"I felt awful, a piece of dirt and they didn't care about me." [61]

The last time she was detained, she had to be hospitalized two hours from home. This was due to their inability to find a bed nearby. If she had insurance or money,[45] she would have been able to stay at the local hospital, she was sure.[11] Oh well. Maybe she would go to the hospital near her sister. The trip would be long and she hated the handcuffs that she would have to endure to get there. Once the police stepped in, it was all over. No arguing with them; you just complied. [62]

She figured she would have to go to the hospital but boy, how she hated it. They treated you like a criminal. First the strip search, then locking you up and making you wear scrubs. Next they would send you to occupational therapy to weave baskets. Everything would be taken from her, even the small ring on her right finger that was given to her by an old love. Sure, she would get it back but without that on her finger each day, the time seemed even harder to manage. [59]

> *"One woman felt that she had been misled and when she found it was a locked unit she just went off. A 'code atlas' was call. She hurt a lot of people but she was already feeling like a caged animal. We then brought in "hulking men". She was on the floor, two months pregnant and four men holding her down…Others were standing around. The patients … they were traumatized*

www.manaraa.com

> *having watched it. They had to carry her through the acute unit …. to a restraint bed into four points…it was disturbing to everyone. You could see the stress the people felt."*[63]

Maybe they would have the hearing the same day she got there. She would be able to go home. The last hearing seemed to take hours as they went through her rights, etc. [64] She still had to stay 17 days, though.[59] Rights? Right! She thought sarcastically to herself.

> *"…told about your rights but you won't get them. They will do whatever they want.*[65]

Sandra. It was laborious, a ridiculous expenditure of Virginia's money. Nothing else could or would describe the job she had been delegated to do by her boss. Sandra Waid had come to this office in January of 1992. Now twenty years later, after achieving seniority finally, she was sent, no banished, to the room of doom. Her task? She was to locate two tapes from commitment hearings after July 2008, #30872-92009 and #584902-82009. She was to do a complete follow up investigation of the disposition and the status of each of the cases, four years later.

She did not understand why, though. Some Virginia delegate, she had been told. He had been a lawyer and then a judge in the years following the Virginia Tech shootings. He had been in a government seat for two years. He was requesting a random assessment of hearings that had occurred across the state and had instructed her to "go beyond the records." She was to do a follow up with significant individuals involved to determine outcomes was his mission. She knew the new legislation had made some positive changes but there were still significant inconsistencies. The Congressman wanted to standardize the civil detainment legislation.[67] Relocate the hearing recordings to an area with light versus this musty, moldy room that reminded you of an old asylum, she thought sarcastically.

www.manaraa.com

Case Number: #30872-92009

Detainee: Donna Hodges

Petitioner: Sandford County Community Services Board

Disposition at the hearing: Released

Criteria for the detainment hearing: Donna Hodges, a 34-year-old female, attempted suicide by overdose on February 23, 2009. She ingested 48 Wellbutrin XL 300 mg each tablet and 20 Xanax 1 mg each tablet. She had been found by her 14-year-old son who contacted 911. Ms. Hodges was taken to the local emergency room where her stomach was pumped and she was stabilized. An assessment was completed at the ER by Taylor Diehr, LCSW and it was determined Ms. Hodges met criteria for hospitalization. A temporary detention order was initiated and she was transferred to County Hospital Psychiatric Center.

Date/Time of admission to the Sandford Psychiatric Center: February 24, 2009 10:00 am

Date/Time of the Hearing: February 25, 2009 10:00 am

Disposition at the hearing: Ms. Hodges was released.

Individuals present at the hearing: Judge Whitley, Danielle Osby, (Counsel for Ms. Hodges), Taylor Diehr, LCSW (Petitioner), Terrance Hall, LCSW (Sandford CSB), Sherriff Hayes (Sherriff for Sandford County), Dr. John Gilliam (Psychiatrist), Dr. Laura Werth (Independent Examiner)

Discharge Plan: Ms. Hodges was discharged into her own care to return to Sandford County. Her place of residence had been secured financially for the next month through donations collected by Mr. Terrance Hall. Her son will remain with his father but she will be

www.manaraa.com

allowed visitation supervised by Ms. Diehr. She will be followed in outpatient therapy by the Sandford CSB. The Sandford Diner has donated a week's worth of meals and Sherriff Hayes, who had taken care of her dog Toddi, has agreed to stop by three times a week to follow up on her condition and her ability to care for her dog. [79/49]

She was discharged on Effexor 75 mg BID and Sonata 10 mg qhs.

Follow-up: February 23, 2012

Corroborating Sources: Terrance Hall, LCSW, Sherriff Hayes, Captain Ted Randall

Current Status of Ms. Hodges: Deceased by overdose, December 25, 2011

This was a particularly hard report to complete. So much information was not in the details. Sandra spent weeks tracking down the identified parties to get more of the details. After four years, everyone had naturally aged and changed their positions in life. Life had also changed them, some for the better and others…not so lucky.

Terrance Hall continued to work at the Sandford County CSB. He was the director of the CSB and talked with her in length about Ms. Hodges. She had been released from the hospital with a discharge plan that seemed to be successful for two years. She remained in treatment with the CSB. She was actively involved with her medication regime and her treatment.[46] The medication regime was difficult due to her lack of insurance.[45] She was using samples provided to her by the CSB, but the CSB was held hostage by the drug representatives as to what samples were available.[42] This meant every six months, Ms. Hodges had to go off her medications and be restarted on the next set of available medications.[68]

www.manaraa.com

> *"If I [the first responder] don't stop the cycle now, will they [individual with mental illness] slide downhill and we will not be able to get them back?....It takes them so long to recover. Do we allow it to go that far?"* [69]

Ms. Hodges' living situation was tenuous. According to Mr. Hall, the county was able to maintain her place of residency through the generosity of the county's citizens. It provided her dignity through empowering her to make personal choices.[49] Her son was 18 now and starting college. He remained with his father and saw his mother very little in the two years that she had lived.[77]

> *"This process is person dependent. I [mental health professional] don't take no very well. I think all individuals have good in them and people do the best they can with the information and skills they have. If any of us (human beings) are involved, 'we' have a responsibility to help."*[70]

Mr. Hall indicated everyone in the county had mourned her death and believed that she did not need to die. The circumstances around her medications, lack of financial stability, lack of family and her mental health were all contributors to her depression and worsening illness.[72] The death was tragic. Many people believe overdosing is the "clean" way to go. It doesn't "leave a mess". What they don't know, he shared, was the effect of death on the body. Defecation occurs, the color of the skin changes...then the smell. He was thankful he had not found her. The sheriff was the one who actually found her as he checked on her every three or four days.[71]

Sherriff Hayes was located at his home. He had retired in December 2011 saying the county needed "new blood." Everyone knew it was due to what happened to Donna. When asked by others whether she was the reason he left, he would shake his head and restate…he just needed a change.

www.manaraa.com

He was reluctant to talk at first. Understanding that this Congressman wanted more than just the facts in an effort to make changes with the civil detainment law, he agreed. There had been some changes over the years, he thought to himself, but not near enough. Education, allowing for the expansion of psychiatric beds, and money were the most critical issues needed if change was to happen, in his opinion.[72]

> *"I think we [first responders] have improved because we are trying to do a lot of community services. We have a short term calming room and can keep someone 3 or 4 hours, offering a cot, food and lounger. We have a person who just works on getting the person into the system of care."* [73]

He talked in length about the two years with Donna and his role in monitoring her illness. He had been the person who found her. She had left a note telling him how much she had appreciated all he had done. But she was tired. "Too tired to continue to fight," she had written. She had apologized for having him find her but of all the people in her life, she had felt he would be able to handle it the best.[74]

Sandra asked him about that. Had he handled it? The Sherriff shook his head and tried to explain the process of compartmentalization, the technique used by professionals to detach from crises and remain effective. He had been haunted for a couple of months with her death. But he was a professional and knew how to take care of himself.[103]

Sandra watched his eyes as he talked. He had not been successful in this technique of detachment on this case.[75] She could tell by the tremor in his voice, how he looked away from her when he talked about Donna. She watched him unconsciously reaching for his dog in an attempt to gain some small amount of comfort. She swallowed hard to keep her own emotions as bay. [75] In an effort to help both of them through the interview, she inquired about his retirement, his home and his dog. The Sherriff's demeanor altered somewhat as he described his retirement.

www.manaraa.com

Talking softly, he shared all that had transpired since he left the force. He shared many colorful stories, as he knew everyone in the county. He had no family but the citizens in the county seemed to have adopted him and he assured her that he was not lonely as he had his "child" beside him, Toddi.

Case Number: #584902-82009

Detainee: James Henry Johnson

Petitioner: Henry Johnson

Disposition at the hearing: Committed for 30 days

Criteria for the detainment hearing: James Henry Johnson, a 22-year-old male, had blockaded himself in a family home, threatening to hurt his family and the president of the United States. He had a diagnosis of bipolar disorder and a history of non-compliance with his medications. This was his fourth commitment hearing. He had a history of psychiatric hospitalizations since age 20.

Date/Time of admission to the Wayne County Jail: August 23, 2011 4:00 pm

Date/Time of the Hearing: November 21, 2011 10:00 am

Disposition at the hearing: Mr. Johnson was committed and would be at the jail until a bed opened up at the state hospital.

Individuals present at the hearing: Judge Smothers, Gabby Redford (Counsel for Mr. Johnson), Henry Johnson (Petitioner), Officer Ted Randall (Wayne County police officer), Dr. Padmini Sarong (Psychiatrist), Ms. India Richards (Regional Jail Psychiatric Nurse), Dr. Tom Watkins (Independent Examiner)

www.manaraa.com

Discharge Plan: Mr. Johnson was transferred to the state hospital on June 12, 2011. He was to remain in the hospital receiving restorative treatment until the doctor released him.

Follow-up: February 23, 2012

Corroborating Sources: Mr. & Mrs. Henry Johnson

Current Status of Ms. Hodges: Mr. James Henry Johnson resides at 4978 Tram Court, Smithfield Virginia.

Sandra was glad to see that the individual from this detainment was alive. She had been shaken by the first report, as she had not considered one could die from mental illness.[76] Her life appeared charmed compared to Donna's.

She had a good job and her insurance had paid for most of her medical care. The co-pays were horrendous and she had a deductible that took a while to reach. But with her current job, she had been able to make ends meet. Her family was large and she received calls daily. They would be asking for this or that. They would share stories of humor and sadness or just call to gossip about Aunt Elizabeth who had done something funny to another family member. In the past, she had been bothered by the calls. Now, she was thankful and would cherish each one as a lifeline should she need them.

Just before leaving to meet the Johnsons, Sandra stood holding her phone to her heart. She lifted it and began to dial, "Hello, Aunt Elizabeth? Yes, it's Sandra. I just thought I'd call to see how you are doing? I could stop by right after my last stop, if that's OK? See you then." Sandra proceeded to pack her items in the car and drove off to see the Johnson's thinking "is it too much to hope for James Henry to have progressed?

www.manaraa.com

Mr. and Mrs. Johnson met her at their home. It was in a neighborhood that appeared to be middle to upper class. They were pleasant and appeared eager to share the story of their son. As Sandra sat listening and gathering the details of James Henry, she was struck by the impact the experience had on them. Lynn was taking anti-depressant medications and in therapy. Henry was taking medications to help with his panic attacks and stabilize his blood pressure.[77] They appeared tired but different from Sherriff Hayes. When they talked, they made direct eye contact and she saw passion in their eyes and heard it in their voices.[77]

Was it passion for their son or was it the fervor she had also seen in the Congressman's eyes when he talked about what needed to happen to get the experience of civil detainment to be standardized in the Commonwealth of Virginia? Sandra had taken a draft of her report to him just two days ago. She listened as he shared with her the reasons for his push for change. He spoke with conviction as he questioned whether the state's money should go to the infrastructure of the highways and educational system instead of the mental health system. Henry would have said emphatically, no! His son had been through hell and back to get to where he was now. He did not think it was with the help of the state. [78]

"Mental health services, it works but it works better if they care about you."[79]

Sandra sat quietly taking notes on the experience of the Johnsons. Lynn Johnson shared her sense of responsibility for her son's illness, as there was a family history of mental illness on her side. She had forgotten the years her mother would talk about her "crazy Nana." Crazy Nana had been "sent away" to the insane asylum due to what she called a nervous breakdown. She acknowledged Henry had not blamed her. Rather she was doing this to herself, as heredity

www.manaraa.com

seemed to be one aspect of her son's mental illness. Going to therapy had helped her gain insight on this but at times, it was hard to remember.[80]

> *"It serves no purpose to blame others. It is easy to blame someone else (the other parent) because of the genetic trait. We did genetic testing ……..and took the risk because we wanted a child."* [81]

Henry Johnson stated his therapy was the golf course. He had given it up during the "dark years" as he called it. Now walking nine holes of golf made his cardiologist happy. The dark years were between 2008 and 2011. [75] He and Lynn acknowledged they never knew when the police would call -- when James Henry would do something dangerous or end up in the hospital. They always felt like they lived on the edge: the edge of their friends, the edge of their families, and the edge of the community. There was still so much ignorance around mental illness.[82]

Sandra asked if they would be all right for her to contact their son. They denied access to him. They had obtained guardianship of him years ago and were very protective of his mental health. They had bought him a home to live in and he was working hard on maintaining his recovery.[83] They did not want someone questioning and upsetting his stability. As Sandra listened to the years of fighting for good care, a knowledgeable doctor that would listen to both James Henry and themselves, watching as their son went through multiple clinical trials for medications, she understood their desire to shield him.[83]

Wrapping up the three hour interview, she asked them to tell her the best and the worst of the last three or four years. After a few moments, Lynn stood and walked to the family photographs. She reached for the photo of James Henry in all his glory, the night he won the trophy for scholarship. The loving smile on her face was replaced by reality. Sandra had only

www.manaraa.com

seen this expression once before, when her best friend lost her son to cancer after a long and difficult death. Lynn slowly turned, the loss seemed to weigh heavy on her. After a few moments of pensive thought, Lynn answered.

"The worst? It was the time I called 911 because James Henry had been in his house for seven days. He had put up a privacy fence around his entire yard. He had called us saying he was going to chop off our heads. When the police were called to his house, they told us to not come as it would be too hard. The waiting was excruciating. When they finally called, he was in their custody. They had to use smoke to get him out and then used the taser on him. Five times, they tasered him."

> *"It was three or four hours of hell. We just sat and waited. The police officer called and said they had taken him to jail. They said he had made a weapon out of a cycle. They shot tear gas into the house through five or six windows and tasered him five times. He still has horrible memories of that time and blames us."*[84]

Henry jumped in the conversation at that point. "Yes, that was the worst. I don't believe they had to taser him five times. We are still investigating that and whether tasers should be limited. You see, I am on the task force in Wayne County to suggest additional reforms [85] related to the response to individuals with mental illness. But the best…?"

Henry thought a bit longer, looking at Lynn and then over at his bookcase of family photos. "Two things stand out in my memory that I would say were the best. One was when James Henry was finally placed in the state hospital. He was able to get excellent care there. It also seemed that he was able to have his rights protected during the hearing as well as during the hospital stay. It was the best in spite of him sitting in jail for nine months before a bed became available.[86] The best part of that time? Was when we were able to come and visit? He reached

www.manaraa.com

over to hug me. I fell apart. I had felt like we had lost our son and now we were getting him back. That hug ….was something I will never forget. "[75]

> *"At the state hospital, the MD was willing to include us, change the medications. He became to feel protected rather than threatened…..the doctors met with us and dealt with family issues and were supportive of us…..he had a great plan for discharge."* [87]

Lynn nodded in agreement and Sandra could see her eyes well up. "And the second?" she prompted. Henry then talked about an incident where James Henry was found under the 5th Street Bridge. An officer called asking me for information about him. I found out later this officer spent two hours with our son talking to him and getting him to agree to go to the hospital. No guns and no tasers. Yes, the handcuffs were used but from what James Henry said, he was alright with them because he understood why."[88]

Sandra thanked both of them for their time and assured them she would take their information to the Congressman. She was confident it would be helpful and left feeling honored. She was honored she had been given this assignment because she knew she had been changed in some way.[75] Maybe the answer was the stories needed to be shared with individuals as these two stories were shared with her.[60] Donna and James Henry were no longer numbers and cases. She had to write a report about people just like her.

Epilogue. Ted Randall had climbed the ranks in the police force over the last four years and was respected by both his men and his superiors. He was now the father of a beautiful baby girl and had been married for two years. His marriage came not long after Donna Hodges committed suicide. He had lost contact with Ms. Hodges after a year post discharge. He was surprised when Henry came up to him and shared with him about her death. He had watched as Henry, his friend, slowed down and seemed sadder at times. [75] Ted would get together with

www.manaraa.com

Henry periodically listening to Henry's trials with his son over the last few years. He tried to help whenever the opportunity arose but felt inadequate to make the changes necessary.

He was frustrated with the "system." He was determined to make changes in the mental health law that directed his force of men and affected so many individuals. Over the years, he had seen many examples of the process. Some in accordance with the legislation and others…well, he wondered about the negative impact on the individual, families and the professionals involved. There were so many inconsistencies around human rights and dignities offered during a civil detainment.

For these reasons, he had taken a position as a trainer of individuals who were "on the scene" first and was moving across town. Ted finished saying his goodbye and packed up to leave the office. The weatherman, Autry was calling for a sunny day with temperatures around 65. Ted wanted to get home as he promised his wife he would take her and their daughter down to the lake today. Ted picked up briefcase and made his way out of the building. Looking up, he felt snowflakes on his face.

Tentative lessons learned

My intention of this inquiry was to understand the phenomenon of civil detainment from multiple perspectives with increased sophistication. After completing the case report, I reviewed the report in its entirety. If I captured the research participants' perspectives correctly, then the following lessons can be held as tentatively accurate. The lessons I describe below are the insights that I as the researcher have "taken away" from this process. These lessons learned are discussed further in Chapter 5.

- Objective and subjective burdens may produce additional stressors experienced by individuals with mental illness and family members.

www.manaraa.com

- Stakeholder groups experience stigmatization uniquely.
- Competing values may produce conflict that may negatively affect the experience of civil detainment when those who ascribe to the medical model of care intersect with those who ascribe to the recovery model of care.
- Civil right violations may occur when practice does not follow policy.
- Crisis intervention team training implemented across multiple localities involving a variety of professionals, emerged as a possibly significant factor in regards to the experience of civil detainment.
- Confusion about civil detainment may be related to lacking the ability to predict danger versus defining mental illness.
- Because of the difficulty with predicting danger, individuals may default to prior legislation, personal values, or the letter of the law when determining if a civil detainment order should be initiated.
- The safeguards in place within the legislation may not be protecting the individual's human rights resulting in civil right violations
- Compassion offered once during the civil detainment process may increase the likelihood that dignity violations are forgiven.
- Individuals with mental illness may be willing to accept civil detainment as necessary to gain recovery
- Mandated treatment fraught ethical dilemmas may act as a barrier to the success of the civil detainment experience, limiting recovery

www.manaraa.com

Chapter 5: Lessons Learned and Implications

Introduction

This inquiry began with the question: "What are the multiple perspectives of the lived experience of civil detainment?" The journey that I embarked on, in an endeavor to answer this question, presented me with challenges, memorable moments, and a deeper respect for the complexity of the experiences of those affected by the policy -- labeled by Guba (1985) as the "policy-in-experience".

This inquiry sought to describe the phenomenon of civil detainment from multiple perspectives in an interpretive paradigm in such a way that would advance understanding of the complexity and nuances of the "policy-in-experience". Characteristic of research conducted in an interpretive paradigm, prediction or causality was not a component of this inquiry.

This chapter reintroduces the conceptual framework discussed in Chapter 4, elaborates on the lessons learned that emerged from this inquiry, and discusses the implications of the lessons for policy, practice and research.

Conceptual Framework

The conceptualized experience of civil detainment that emerged from the analysis was the interplay between the five constructs previously identified in Chapter 4. For each individual involved, the *influences that impact the experience*, *the application of human rights*, and *the needs for recovery* varied and intersected in different ways. These variations among the intersecting forces produced unique *experiences of civil detainment* and *emotions* for each individual in the civil detainment process. Although the case report was context bound and not generalizable, the implications may be considered appropriate to other similar contexts.

www.manaraa.com

Like basketry, the experience of civil detainment was both a process and product of labor by and for specific individuals. Each experience of civil detainment was different. Any one factor such as financial resources (affluent or not), locality (rural vs. urban), the discipline of individuals involved in the detainment process, and the inclusion or exclusion of CIT officers contributed to the variation in civil detainment experience. Like baskets, some civil detainment experiences were more beautifully crafted than were others.

Lessons Learned

The lessons I describe below are the insights that I, as the researcher, "took away" from this inquiry process. When I began this journey, I expected to find the majority of individuals with mental illness to be terrified of civil detainment and to view the experience as both traumatic and unnecessary. However, I found there were aspects of the experience of detainment welcomed by the individual with mental illness as it provided an opportunity for recovery. In respect to families, I expected to find the families in favor of civil detainment as a means to ensure safety when in fact families were more invested in alternative treatment options that did not include civil detainment. Finally, I expected the professionals involved in the civil detainment process to be clear about the civil detainment policy, confident in its purpose and role in the life of an individual with mental illness, and more concerned about the safety of the community versus the dignity and respect of the individual detained. In actuality, I found the professionals involved to be experiencing the majority of the angst over how to implement the civil detainment policy and to ensure that the experience provides dignity and respect.

In spite of being in the field of mental health for over two decades, I was surprised by the feelings and new insights I experienced. As I became a witness to individuals' stories and experiences, I found myself experiencing emotions of shame, sadness, disorientation, surprise,

www.manaraa.com

intrigue, sympathy, empathy, curiosity, and anger. As a witness, I was both honored and humbled by the depth of passion, resourcefulness, and tenacity involved in the provision of care offered to individuals who were in crisis. As a professional in the mental health field, I began to reevaluate my values, perspectives, and beliefs about civil detainment-particularly those pertaining to Alice.

As I reflect about the previous four years and consider where Alice is now in her life, I wonder how the civil detainment experience altered her life. Alice permanently moved out of state after discharge from the psychiatric hospital and terminated services with me two years later. She is no longer a client of mine so I am unable to question her current perceptions and beliefs about the impact of the experience of being detained. However, we did maintain limited and periodic contact and I am aware that she had moved to Tennessee. Her husband had obtained a restraining order against her and had successfully petitioned the court to restrict her from all contact with her children subsequent to the civil detainment. Without gainful employment and no spousal support, she had no funds to live independently in the area. Her biological family in the area had refused to allow her to live with them and, thus, she was living with her ailing grandmother in Tennessee, waiting on a divorce initiated by her husband.

Alice had been trying to acquire outpatient mental health treatment in Tennessee, but due to a lack of insurance, a lack of financial resources, and a lack of private providers, her only option had been the community services boards. The CSB had placed her on their waiting list and the staff indicated that she would begin treatment in three months. She was told that her treatment would be comprised of 10 bi-weekly outpatient therapy sessions. She had communicated with me sporadically via telephone that she struggled every day to maintain her emotional health while awaiting treatment.

www.manaraa.com

Now with my inquiry complete, I am clearer that the individuals in her life such as her husband, friends, and the hospital staff were not the only forces that contributed to Alice's detainment. Alice may have been impacted by my 'expert bias' as defined in the literature (Poletiek, 2002). Poletiek (2002) found that experienced clinicians had a higher threshold for potential danger than the newer mental health clinicians did due to their greater expertise and history with individuals with mental illness. As a result, the experienced clinician detained individuals differently. As an experienced clinician, I had a level of comfort at managing a sense of danger and had not detained Alice earlier in her treatment. I had determined that she was not in danger of hurting someone else, given my definition of 'imminent danger'.

A less experienced therapist may have initiated a civil detainment order earlier in Alice's treatment due to her history of multiple threats to harm others and her serious mental illness. Studies have found that differences in levels of training are associated with inconsistencies in civil commitment assessments and treatment (Brooks, 2012; Poletick, 2002; Roth, 1979; Zemishleany, 2007). I now consider this 'expert bias' a factor in Alice's situation and I wonder whether Alice's life would have taken a different course if I had detained her earlier.

In the following discussion, the interview word data and the observations offered by the multiple stakeholders are incorporated to highlight specific examples of the lessons learned. If you, as the reader agree with my interpretation presented in the case report, you may use the scholarly literature noted in this chapter as a point of reference. If my construction of the multiple perspective of the civil detainment experience is accurate, then the lessons I have drawn from the experience may be regarded as true only within the context of this inquiry. Each of the lessons learned in Chapter 4 are grouped under their corresponding theme outlined in the conceptual model.

www.manaraa.com

Influences that impact the experience. My inquiry helped me to identify and understand the many different factors or influences that impact the experience of civil detainment. One of the most common influences was a sense of "burdening"**.**

Objective and subjective burdens may produce additional stressors experienced by individuals with mental illness and family members. Objective burdens for the families of individuals with mental illness who require treatment are identified in the literature as concrete costs, such as the disruption of daily life and necessary financial expenditures (Jungbauer, Wittmund, Dietrich, & Angermeyer, 2004). Participants in my inquiry reported they experienced similar objective burdens such as taking days off from work or spending time setting up mental health appointments for the family member with mental illness. More than one interviewee described custody fights for children after a mental illness was identified and a civil detainment experience occurred. The cost of the lawyer, the time away from work to attend court hearings, and the cost of the therapist or psychiatrist to testify in court were all examples of the objective burdens.

Jungbauer, et al., (2004) asserts the need for changes in the mental health system to assist family members in their efforts to care and support the family member with mental illness. Objective burdens experienced by the participants in my inquiry included an inability to access treatment, additional costs for treatment, and the caregivers' need to assume multiple roles. For example, one mother and father moved to the university where their son was enrolled. The parents alternated sleeping on a cot in a one-bedroom apartment for two years in an effort to support the son's educational efforts. The cost of the apartment, the time off that one parent had to take from employment and the inability to access needed treatment and mental health providers necessary for stabilization of their child's mental illness were examples of objective

www.manaraa.com

burdens. Another family purchased a residence to provide a place for the family member with mental illness to live independently as his illness prohibited him from making a substantial livelihood to pay for housing. Families also reported paying larger psychiatric copayments than medical copayments. In sum, the participants in this inquiry identified and experienced objective burdens such as lack of funding for treatment, lack of parity for medical care reimbursement, and the lack of alternative treatment opportunities outside of inpatient psychiatric care.

Subjective burdens as discussed in the literature have included the family's perception of their role in relation to the needs of the individual with mental illness and the degree to which this role was perceived as burdensome (Jungbauer et al., 2004). My interpretation of subjective burdens experienced by the participants in this inquiry included indignities such as exclusion, isolation, shaming, and being misunderstood. Families described ostracism and exclusion from clubs and activities, loss of friends, and distancing of family members from both the individual with mental illness and his or her nuclear family.

In addition, families reported experiences of rejection from both the professionals and the community. For example, professionals made pejorative comments to the individual with mental illness in the family's presence and employers asked the individual with mental illness whether his illness was caused by his use of drugs or whether other family members were mentally ill. When the individual with mental illness was hospitalized, family members reported a sense of isolation and a feeling that others "would not understand". Similar to the literature, family members in this inquiry reported experiencing "shame" (Ahlstrom, Sharsater, & Danielson, 2010; Angermeyer, Schutze, & Dietrich, 2003; Corker 2001; Hallam, 2007; Mateu & Cuadra, 2007) and experienced episodes of the absence of caring, lack of understanding, and withdrawal of care by professionals (Finkleman, 2000; Sartorius et al., 2005).

www.manaraa.com

Stakeholder groups experience stigmatization uniquely. Each of the stakeholder groups, with the exception of the judicial system, reported experiencing stigma in a unique way. No group self-identified their own use of stigmatizing language. Beliefs pertaining to individuals with mental illness emerged during the interviews in both overt and covert language of first responders. Stigmatization of individuals with mental illness was reflected in the language used by individuals in the first responder stakeholder group. Overt examples included judgmental comments lacking understanding of the subjective experience of mental illness. First responders used labels such as "frequent flyers," "but very likeable," and "she looked like a normal person". They implied that individuals with mental illness were weak and at times responsible for the illness and/or the lack of recovery. These experiences appear to be similar to the McGravey (2008) study findings of an "us versus them" mentality and a belief that individuals with mental illness may be bad or criminal.

I was surprised to find that the same mental health professionals who railed against the disempowerment of individuals with mental illness also used pejorative and judgmental language when describing these individuals. Examples of this included statements such as "we try to supervise them," or "we see a lot of people that are 'malingers,'" or a description of one the individual who frequently "drinks at home, calls us to say he is suicidal, and then comes to the ER and is jolly". Such statements may suggest that these professionals judged the individual with the mental illness as malingering or lazy and reinforce stigma defined as labeling and stereotyping (Link & Phelan, 2001, p. 363).

The literature has suggested that stigma leads to increased isolation and misunderstandings (Corrigan & Wassel, 2008; Geller, 2007; Larson & Corrigan, 2008; Link & Phelan, 2001; Lopez, 2002; Morden, Mistler, Weeks, & Bartels, 2009). Similarly, I listened as

www.manaraa.com

family members in this inquiry identified instances where neighbors stared at them when they left their home and then avoided them after witnessing the police removing a family member in handcuffs from the home. A mother of a son with mental illness stated her sister told her that she (the sister) did not want to hear any more about her nephew's illness. This mother stated that her sister would not have made that comment if her son had a chronic medical illness. She reported that many times her family suggested that she needed to show her son "tough love" or "let him go" suggesting that his actions were voluntary, manipulative and not due to a mental illness. Extended family members remained emotionally distant and asked very little about how the family member with mental illness was managing day to day. Families referred to carrying a "badge of shame" and a sense of "responsibility" for the illness due to "bad genes".

In contrast to family members, individuals with mental illness whom I interviewed did not initially answer the question about stigma and dignity violations directly. Rather, common responses included, "I [the individual with mental illness] didn't care what others thought," "I [the individual with mental illness] was more grateful for the opportunity to recover," and "I [the individual with mental illness] fight against it [stigmatization]." As I probed further, following different verbal and non-verbal expressions in the interviews, these same individuals shared their perspectives on stigma. Some of the individuals with mental illness shared how coming to "not care" about others' opinions was a "journey to not caring". They stated they "see no stigma as they fight against it". One woman expressed gratitude for the chance of recovery, but observed "[her] cousins still glance [ing] her way and talk[ing] in whispers."

I interpreted the initial lack of discussion from individuals with mental illness as a by-product of understanding stigmatization in his or her unique way. As I probed further, participants described stigma as the rejection by others, being called "crazy", or seen as

www.manaraa.com

dangerous. Corrigan and Watson's (2008) findings that after an individual has been determined to have a mental illness, his or her reputation, privacy, and equality in the medical arena is jeopardized. Individuals with mental illness also related episodes when professionals participating in the detainment process did not accept the clinical information offered by the families or the individual with mental illness' private psychiatrist. This experience occurred when a diagnosis of a mental illness was known.

This lack of acceptance resulted in additional indignities including the need for the individual to explain his or her illness and to justify the need for treatment repeatedly. The individuals interpreted the disregard of their information by the professionals and families as a consequence of stigmatization. This disregard perpetuates a perception that those individuals with mental illness and their families are mentally "defective" and are unable to fully understand and communicate the nuances of their illness.

As a clinician in the field, I can recall behaving in similar ways (asking for repeat information and repeating questions in multiple ways) as an aspect of the assessment process. My goal was to ascertain the level of severity and whether the individual could be treated within the organization that I represented. Without a conversation about my intent and reasoning behind my behavior, I am confident that many of my actions were attributed to similar beliefs that I was questioning the individual's ability to understand the nuances of his or her illness.

Competing values may produce conflict that may negatively affect the experience of civil detainment when those who ascribe to the medical model of care intersect with those who ascribe to the recovery model of care. Although I was familiar with the differences between the two models of care, the majority of my professional career has been within a medical model. In the case report, Susie's story reflected the medical model (Chow & Cummings, 2000; Sadler,

www.manaraa.com

2005; & Sharfstein, 2000) that subscribes to a standardized set of procedures in a prescriptive manner while in the hospital and then once discharged; her plan for continued care reflected the recovery model of care. Defined as independence from a value system, my case report did not reflect a value-neutral classification scheme to determining mental illness (Perring 2010). In other words, my interpretation of the multiple perspectives reflected that the process of determination of civil detainment is value laden.

The existence of a recovery model that views recovery as a process rather than a failure (Corrigan, 2002; Corrigan & Lundin, 2001; Jacobson & Greenleyk, 2001; NASW, 2000b; Ralph & Corrigan, 2005) is also reflected in the case report of Susie and James Henry's story. For example, individuals with mental illness, families, and mental health professionals in the inquiry spoke of recovery and referenced recovery as a journey and not as an "end" -- a journey that requires options to be successful. The path to recovery for one individual may be very different from the recovery path for another.

Individuals with mental illness who I interviewed verbalized preferences for the recovery model as it afforded them an increased awareness of new treatments, more independence, a sense of control over their life, and an increased potential for choosing options related to recovery resources. Options for recovery included the use of psychiatric advance directives, alternative support options such as peer-to-peer support groups**,** wellness recovery action plan facilitator trainings, and peer-run drop-in centers. Individuals with mental illness and families also felt these resources should be made available both before and after a civil detainment experience. In the participants' experience in the Commonwealth of Virginia, such resources have not been routinely available to all individuals with mental illness due to a lack of resources in certain localities.

www.manaraa.com

In the first responders' stakeholder group, the case report reflects how these first responders strove to accomplish a plan of care reflective of the recovery model; and yet, once the civil detainment process moved to a hospital facility, the medical model trumped the recovery model. For example, once an individual is admitted to a medical facility, he or she may be faced with forced medications. The medical model may lead to situations where the individual with mental illness feels disempowered. In my inquiry, participants described the removal of basic rights to choose the contents of his or her meal while in the hospital, the lack of autonomy to make treatment decisions, and the inability to refuse medications as violations of their civil rights..

Prior to the inclusion of the CSB evaluator as the decision maker for civil detainment, the psychiatrist had been the primary expert in the determination of civil detainment (Applebaum 2006). The psychiatrist as the expert determining civil detainment epitomizes the medical model typically seen within a hospital setting.

In my inquiry, competing values were found in the treatment teams in the psychiatric hospitals. Mental health professionals such as social workers expressed frustrations with the "doctors' agenda" and perceived this agenda as negatively influencing the individual's progress and recovery during treatment (i.e. a physician deciding to prescribe medications that the individual detained had reported as ineffective in his or her past psychiatric care). Furthermore, many of the mental health professionals I interviewed described other professionals taking "liberties" under the auspicious of the medical model that degraded individuals with mental illness through "off-hand" comments or non-verbal gestures. Examples included treatment team staff members in psychiatric hospitals, for no known medical rationale, provoking individuals with mental illness to react to certain stimuli despite knowing that the "taunting and bating"

www.manaraa.com

would exacerbate the mental illness' symptoms. These experiences demonstrated the power of the identified expert, the psychiatrist, in a medical model of care.

Conversely, psychiatrists verbalized anger and frustration when their power was perceived diminishing by newer aspects of the civil detainment legislation that required the CSB employee to assume the lead in determining the appropriateness of a civil detainment request. The psychiatrist perceived his or her medical judgment as being questioned by less trained individuals. An example given in this inquiry involved a psychiatrist who tried on two different occasions to have her client admitted to the hospital via a civil detainment order. In spite of her extensive training and knowledge of her client's past and current psychiatric history, the CSB pre-screener denied the request for a civil detainment.

Professionals continue to support the medical model's paternalistic approach (Perring, 2010 & Wand, 2012) as being in "the best interest of the individual and family". This model of care runs parallel to the social contract theory as both the medical model and social contract theory utilize a paternalistic approach to the detainment of an individual with mental illness. Both assume the responsibility for the care and welfare of the individual with mental illness. Like the government under Social Contract Theory, physicians in the medical model of care have the potential to intervene into and limit an individual's autonomy and liberty to ensure the safety of the individual, family, and community by virtue of their position and power. This action by the government and the physician is paternalistic (Beauchamp & Childress, 2001; Cody, 2003; Friend, 2004; Gauthier, 1986; Mill, 1959; Rawls, 1971).

My interpretation of the multiple perspectives is that both models of care are value laden and the experiences within the models are significantly different in terms of the options available for recovery. This lesson learned led me to the question if a lack of movement of the recovery

www.manaraa.com

model to become the preferred model of care by professionals may be a tertiary consequence to the strong unspoken connection between the medical model's paternalistic approach and the implied social contract operating in the Commonwealth of Virginia's culture.

Civil rights violations may increase with variations in education and training and the lack of infrastructures that offer resources. Excluding those situations where CIT trained law enforcement officials were involved, all stakeholder groups reported problems with law enforcement officers' general lack of training and education about mental illness. Some individuals with a mental illness described the experience of fear associated with police officers' lack of training and education related to the subjective experience of mental illness. They feared losing autonomy to the police, being misunderstood, or being taken to jail as a violation of their civil rights.

According to the interviews, many of these fears were based in their subjective reality of past experiences. Individuals with mental illness shared experiences of being restrained, being treated roughly, and experiencing "no voice as police run the process". Examples included telling the individual with mental illness to "go ahead jump we [police officers] are tired of you" and "we [police officers] will put you in handcuffs, parade you in handcuffs through the ER, and then march you in a mental hospital." All of these examples demonstrate a lack of education and training about the origins of mental illness and an individuals' ability to control the illness. These examples also demonstrated a lack of training and education as to how best to interact with individuals who may be struggling with a mental illness.

The fear of the unknown was a common denominator of families when discussing civil detainment and police officers. Participants worried about "police killing individuals with mental illness," "police were being rough," "never knowing when the police will be coming,"

www.manaraa.com

and "police in full body armor." Police enforcement professionals expressed similar concerns, "There are good and bad ones [police officers]." These inconsistencies between the behaviors of law enforcement personnel may be decreased through consistent training curriculums. The fear of interacting with police officers who lacked training was intense for family members interviewed.

Repeatedly, participants' detained and family members stated that police training in law enforcement policy may not address the needs of individuals with mental illness and thus many police officers followed the letter of the law as applied to criminal offenses and did not exercise personal autonomy when making decisions in the best interest of those suffering mental illness. The result is that the individual with mental illness experiences a sense of dehumanization. Frequently the lack of autonomy demonstrated by a police officer was perceived by the individual and/or family involved in the civil detainment as a lack of caring.

Another variation associated with civil rights violations involves infrastructure, defined as those resources required for an activity (Merriam-Webster, 2012). Participants perceived a lack of resources such as hospital beds, necessary monies, crisis stabilization units that could support and treat the individual in need. Regional variations of these resources may have resulted in a lack of consistent treatment and on-going care for the individual with mental illness across the Commonwealth.

Participants reported anger and frustration about the obstacles or barriers they ran into when attempting to find treatment options such as crisis stabilization units, specialized outpatient clinicians, etc. The lack of alternative treatment options such as centralized drop offs, mobile crisis units, psychiatric emergency rooms, inpatient beds, outpatient providers, and nearby drop-in facilities was experienced as a negative influence on the experience of civil detainment and

www.manaraa.com

the well-being of the individual with mental illness. These negative influences, lacking infrastructures, were experienced more in some localities than others, resulting in the experience of civil detainment varying significantly. The lack of infrastructures, at times, prevented the provision of mental health treatment in the least restrictive environment.

In McGravey's study, hospital beds and alternative services such as drop in centers were unavailable due to a myriad of issues such as funding and/or a lack of certificates of need (CON). My interpretation of the experiences of civil detainment found in this inquiry may appear similar to McGravey's (2010) findings in the examination of civil commitment in the Commonwealth of Virginia. It was not unusual for me to hear about decisions about where to live tied to a locality's ability to provide for the care of individuals with mental illness.

With the increase in a geriatric population, stakeholders in the mental health professional and first responder group reported an expectation that the need for care and treatment of geriatric individuals will increase. Without the proper resources, the civil rights of this specialized population is jeopardized. Treating a geriatric individual with mental illness adds another layer of complexity to the experience of civil detainment due to the need for additional specialized treatment resources and specialized facilities due to the multifaceted medical needs (Cummings & Kropf, 2011).

In one area of the Commonwealth, the first responders report that if an individual with dementia suffers mental illness that precipitate a detainment process, there "are no options for mental health care" because psychiatric units in the vicinity claim dementia as an exclusionary criterion for admission resulting in a lack in the availability of inpatient psychiatric care. Thus, individuals with mental illness were returned home to an unsafe situation. If returning home was not possible, medical reasons were devised to admit the individual to a medical unit resulting in

www.manaraa.com

the individual being treated by non-psychiatric staff. This resulted in geriatric patients being treated by nursing staff who were potentially working outside of their scope of practice.

One rationale offered for not admitting a geriatric individual with mental illness and dementia to a psychiatric unit has been safety. Psychiatric staff may not have had the training necessary to provide for the medically complex needs of the geriatric individual. Conversely, staff assigned to a medical unit may not have had the training to provide for the complex mental health needs of the geriatric individual. Additionally, psychiatric units may not be equipped to manage the complex physical needs such as ambulation that emerge when an individual's health is compromised due to the aging process. Not surprisingly, , some professionals interviewed were concerned that admitting a geriatric individual with dementia and mental illness to a psychiatric unit potentially threatens the safety of other geriatric patients on the unit..

Yet the refusal to admit the geriatric individual with mental illness to a psychiatric facility may jeopardize the mental health of the geriatric individual and their civil rights (Cummings & Kropf, 2011). One example of potential risk for the geriatric individual with mental illness offered is the complexity of prescribing psychotropic medications. The complexity, due to the nuances of combining psychotropic medications with medical medications, and the potential consequences to the aging individual necessitates the need for specialized medical staff managing the medication regime (Schwarz, Froelich, & Burns, 2011; Stanton & Kohn, 2012; Virginia Department of Behavioral Health and Developmental Services, 2011).

Several experiences have transformed my understandings about the impact of the lack of infrastructure and the civil detainment process. The following example is just one instance,

www.manaraa.com

offered to me in the interviews, of the complex issues surrounding the provision of adequate civil detainment infrastructures.

In one rural community, the sheriff's office closes at four in the afternoon. This results in the loss of space for a civil detainment assessment. For this reason, individuals detained are brought to the area hospital and are admitted to the ER for the assessment. The admission to the ER includes blood work, being seen by a medical physician, and being held until the CSB staff arrives to complete the evaluation. The mental health evaluation for civil detainment is then completed in the emergency room cubicles, which have been protected only by sheets across the openings between cubicles.

The first responder who described the situation to me shared her discomfort at completing a mental health assessment without privacy. She also verbalized a sense of outrage at the lack of respect she experienced for herself as the medical staff ignored her request and ignored the individual with mental illness' emotional needs and right to privacy. She reported that her requests for privacy in the process of assessment was not valued, in spite of the fact that assessments conducted in this manner jeopardized confidentiality. In addition, the individual with mental illness may not have needed the additional tests and yet bills were incurred.

In this example, when the assessment was completed, the individual detained was handcuffed again. He/she was then transported to another hospital with an available psychiatric bed. Once the individual arrived at this next facility, he or she then have had to go through the another emergency room for admission, complete another mental health evaluation by the emergency room mental health staff, and incurred another medical bill. This long and arduous process occurred prior to the psychiatric admission and the civil detainment hearing.

www.manaraa.com

A lack of an infrastructure that offer resources to the stakeholders involved in the civil detainment process may jeopardize the care of the individual with mental illness, risk privacy, and create additional steps that may increase the risk for dignity violations and civil rights violations for all stakeholders; in particular, the individual detained.

Civil right violations may occur when practice does not follow policy. Participants from the first responder's group also shared the potential risk to individuals' physical safety when personal judgment trumps policies. All stakeholder groups described a lack of standardized practice regarding the use of handcuffs. Although most areas of the Commonwealth discussed by the participants utilize handcuffs as standard policy, some localities had altered the handcuffing policy to allow officers to use personal judgment in the practice of detaining an individual with mental illness. Unfortunately, within one of these localities, an individual who was detained but not handcuffed shot and killed the police officer. This tragedy resulted in the reaffirmation of the policy and standardized practice of handcuffs in that locality. It serves as one argument for standardized policy and practices and yet, when policy operates in a "one size fits all" mentality, individual civil rights may be jeopardized.

Assessments for civil detainments are conducted in a variety of locations. This results in a lack of uniformity in the experience of civil detainment. The decision about the location of the evaluation is not always driven by the individual's medical or mental health condition. At times, the emergency room is used as the location for the civil detainment assessment due to policies developed at a local level designed to address a lack of secured locations. If the assessment is conducted in an emergency room (ER), the experience of civil detainment is very different from an assessment that is conducted at the CSB facility.

www.manaraa.com

According to participants, emergency room staff operates predominately under the premise that no assumptions are made about the medical and mental health condition of an individual brought to the ER. This premise results in the emergency room staff conducting multiple tests to ensure the medical safety of the individual detained and of the emergency room staff. For example, an individual with mental illness may have ingested multiple medications, which endangers his or her life. If definitive information about the individual's medical condition is not offered by the individuals on the scene (the individual detained, family members, mental health professionals, and police), then serious ramifications may occur if the individual detained had attempted to commit suicide through the ingestion of medications, cutting major arteries, or was medically jeopardized through lengthy restriction of food.

For these and other reasons, the medical professionals interviewed in this inquiry defended the rationale for medical testing of all individuals admitted to the ER. The fourth amendment states that the performance of medical tests with probable cause does not violate an individual's constitutional right to privacy (Schmerber v. California, 1966). If the individual is deemed to be lacking the capacity to understand the request, then the probable cause factor increases as it pertains to forced medical proceedings. The question arises, yet again, how and who determines a person's competency, especially as it has been determined that there are no standardized tools to determine competency (Appelbaum, 2006).

If individuals with mental illness are considered incompetent and no assumptions are to be made about the individual being assessed for a civil detainment, should the location of all assessments be at the emergency rooms and a full diagnostic examination completed? If the policy implementation is standardized and all individuals detained will be assessed in the

www.manaraa.com

emergency room, than *all* individuals detained would be required to comply with medical treatment such as blood work and may then receive equal treatment across the board.

Crisis intervention team training implemented across multiple localities involving a variety of professionals, emerged as a possibly significant factor in regards to the experience of civil detainment. Prior to this inquiry, I had little to no information related to crisis intervention training (CIT). As I learned about the CIT training, I became excited and energized at the possibilities it presented in terms of protecting the dignity of everyone involved in the civil detainment process. CIT training has been designed to "educate and prepare police officers to recognize the signs and symptoms of mental illness" (Ballantine, 2011, para 1), and to prepare first responders to behave effectively and appropriately in regards to individuals in a mental health crisis. CIT has been offered to police officers in various localities within Virginia.

I was surprised to hear that many first responders were resistant to the CIT training they referred to as "hug a thug" training. I was told that most of the resistance was due to ignorance about the purpose and use of CIT training. The participants reported that once CIT training was completed, the responses of the individuals involved in CIT training were overwhelmingly positive. Participants noted that the new training (CIT) had made a significant changes.

Approximately half of all participants reported experiencing positive experiences with the police. For instance, individuals with mental illness and their family described the "police [as being] supportive," or said, "we [family] called and they came". According to participants, police with CIT training were "more alert and responsive to the nuances and the symptoms" of mental illness. Participants found that police officers were "cooperative for the most part, knowledgeable and [could] make a decision on the spot". During the interviews, individuals' interviewed in all stakeholder groups reported how law enforcement officers' actions were

www.manaraa.com

designed to help maintain dignity. For example, one police officer took hours to talk to an individual with mental illness under a bridge--calming, educating, and creating a detainment process filled with dignity.

The phenomenon of "muscle memory", as defined by one first responder, occurs when officers act without conscious thought. This behavior is a by-product of law enforcement training, the experience on the job, and the physiological process that occurs when someone is regularly involved in crises.. According to first responders, law enforcement personnel are encouraged to act "automatically" and "make basic decisions" rapidly. CIT trainers reported that CIT training was able to alter these automatic responses. CIT training encourages the police officers to take additional time "on the scene" to slow automatic responses – the muscle memory -- and allow for cognitive processing. This additional time allows police officers the opportunity to slow his or her adrenaline and build trust among the varying parties involved. Developing a level of trust allows the law enforcement personnel to work towards a peaceful resolution of the crisis through negotiating and compromising instead of through use of force.

Participants reported that sensitivity was enhanced if the police officer took additional time during the civil detainment process. The complexity of mental illness and the lack of a visible injury meant law enforcement personnel had to take longer than the normal allotted time for a "call" to be resolved. When time was extended, both individuals with mental illness and families described police officers as advocates for the family with the CSB and able to promote dignity. Even though many participants believed that "they [law enforcement] were getting better, the interviewers also verbalized that law enforcement had "a long way to go".

First responders shared their efforts to include the medical community in CIT training, but reported minimal success. Participants from each of the five stakeholder groups related that

www.manaraa.com

the civil detainment experience may improve if nurses and medical staff receive training focusing on the subjective experience of mental illness. The program of CIT is primarily conducted in the area of law enforcement and has yet to be tested in the medical community.

Given that all stakeholder groups report dramatic changes resulting from the CIT training, I believe that that the experience of civil detainment would be improved if families, medical professionals, and other professionals involved in the detainment process also completed the CIT training. There have been no empirical studies of the impact of CIT in the Commonwealth of Virginia.

Studies across the country appear to support CIT training as a positive training curriculum. Research studies found that CIT officers reported being well prepared and a sense of efficacy when involved with individuals with mental illness as compared to non-CIT trained officers (Compton, Bahora, Watson, & Oliva, 2008; Geller, 2008; Morrissey, Fagan, & Cocozza, 2009).

Confusion about civil detainment may be related to lacking the ability to predict danger versus defining mental illness. The debate over whether mental illness is of organic origin or a result of psychological or societal causes has continued (Gutting, 2008; Szasz, 1974). There has been difficulty with defining the exact nature of the illness because of the questionable influences of environmental and societal factors, i.e. co-morbid medical disorders increase the challenge of determining its origin. The American Psychiatric Association (1994) states that beliefs about the causes and treatments of mental illness have continued to evolve contributing to confusion and a tension between multiple definitions of mental illness. However, the participants in this inquiry did not discuss confusion or demonstrate tension over the definition of mental illness.

www.manaraa.com

In this inquiry, I interpreted the confusion experienced by the interviewee regarding the ability to predict dangerous and how dangerous must a person be to constitute civil detainment. Without clear direction from the legislation, the ambiguity of terminology and the lack of being able to predict dangerousness may leave a wide range of potential interpretations and inconsistencies and may increase the likelihood that implementation of the civil detainment policy is "person-dependent".

I did not find the stakeholders in this inquiry to be juxtaposing with others about a definition of mental illness. From the analysis of the data, I found almost no discord as it pertained to an understanding mental illness. This conclusion developed due to the lack of dialogue by all stakeholders in the interviews about determining the existence of a mental illness.

In particular, there were significant differences in the understanding of criteria regarding the level of danger that is necessary for detainment and the definition of "near future" versus "imminent." In my interviews, I found that all stakeholder groups struggled with confusion around this terminology, particularly in regards to predicting the course of the mental illness and the risk for danger in the future.

All stakeholder groups described personal experiences with variations in the application of the civil detainment criterion of dangerousness and the need to predict the likelihood of danger. For example, the new legislation has defined "near future" to mean seven to ten days from the day of assessment. The previous legislation interpreted "imminent future" as within 24 hours. Mental health professionals and first responders described predicting danger as being as possible as "nailing jello to the wall." The inconsistent determinations of future dangerousness due to various interpretations were identified as obstacles for families. Families reported that

www.manaraa.com

each individual in the process of civil detainment could interpret future danger differently. The result may be varying outcomes of civil detainment orders.

Without a standardized way to predict danger (Appelbaum, 1988; Eisenberg, 2005; Sadoff, 1978; Schopp & Quattrocchi, 1995), treatment may not be offered uniformly to individuals with mental illness. Predicting danger opens the door for treatment (Pescosolido, Monahon, Link, Stueve, and Kikuzawa, 1999). For this reason, inconsistent interpretation is a problem for stakeholders in the civil detainment process.

An example given was Sam (pseudo name), a 17 year old individual whose mental illness had become exacerbated. Sam had made threatening gestures towards his parents, was non-compliant with his medications, and stayed awake at night roaming around the first floor of the family home. The family believed Sam was in need of a more restrictive level of care. In the previous 2 years, the family had experienced Sam stopping his medications and not sleeping for extended periods on two separate occasions. On each occasion, Sam had become increasingly combative towards his family including physical altercations with his mother. The first assault resulted in his mother's arm being broken; the second assault resulted in significant bruising to his mother's face.

During the current assessment by the CSB staff, Sam reported that he would not hurt his parents and would sign a written safety contract. The CSB staff stated that Sam did not meet the criteria for admission since his level of danger was not imminent. The lack of criteria as defined by this particular CSB staff resulted in no treatment. Sam was a minor; his family was still legally responsible for him and yet Sam staying in the home jeopardized the family's safety (they slept behind locked doors due to threats of harm). Without mandated treatment, the family's

www.manaraa.com

recourse was to wait for Sam's illness to worsen to the point when an actual attempt to harm himself or others was made.

The new legislation was altered in 2008 to increase the period for consideration of potential danger. The CSB staff in this example evaluated Sam under the previous legislative criteria incorrectly, stating that Sam was not in imminent danger to himself or others. If the CSB staff had operated under the new legislation that was in force during Sam's evaluation, Sam would meet the criteria for civil detainment as his previous pattern of de-compensation had been established and a potential risk of danger could be predicted. The difficulty with predicting danger (Appelbaum, 1988; Eisenberg, 2005; Sadoff, 1978; Schopp & Quattrocchi, 1995) may lead prescreeners to fall back on the "old" legislation.

In the example of Sam, the issue of safety was evaluated using criterion based on the previous legislation. Although Sam's right to liberty was protected, his right to receive treatment and his family's right to safety was denied.

An ethical dilemma is defined as when a moral decision must be made between two options; each possible but not at the same time emerged. The individual cannot "win" and is condemned to failure as no matter what is done, he/she will do something wrong (or fail to do something that he/she ought to do) (McConnell, 2010). In this example, both Sam and his family's rights could not be protected at the same time – the evaluator chose to utilize the old criteria to make the determination.

According to the participants in this inquiry, the new danger timeframe criterion has not been consistently implemented across the different localities or within any one organization involved in this inquiry. This may have been due to personal values, professional expertise, and/or beliefs by individuals completing the civil detainment evaluations. In spite of the

www.manaraa.com

standardized training regarding the new legislation, mandated timeframes are not consistently implemented across all localities or organization. The inability to predict danger may affect the decision making process when a civil detainment order is initiated allowing and increase the lack of uniformity related to the criterion of danger and civil detainment.

The application of human rights.

Because of the difficulty with predicting danger, individuals may default to prior legislation, personal values, or the letter of the law when determining if a civil detainment order should be initiated. Social workers in the role of mental health professionals and first responders stated that individuals with mental illness were being evaluated based on both old and new civil detainment policies. Some participants expressed the belief that a complete turnover of staff with each CSB organization may be necessary to achieve a consistent application of the civil detainment criteria. The safety of the community in this study trumped an individual's rights depending on the professional's choice of criteria used in the assessment.

Choosing different criteria to use in the determination of the civil detainment may be the result of both professional experiences and personal values. One mental health professional gave the following example that illustrates the complexity of professional experiences, personal values and the influence on the experience of civil detainment.

Safety of the community may supersede the individual with mental illness. The case report illustrated the theoretical framework underpinning this inquiry; Social Contract Theory. Social Contract Theory is based on an *interpretation* of behavior attributed to mental illness (Friend, 2004; Gauthier, 1986; Rawls, 1971). The civil detainment policy is designed to balance the rights of the individual with mental illness that is not dangerous with the rights of the community.

www.manaraa.com

In her interview with me, Shana (pseudo name) a social worker, shared that she had assessed an individual with mental illness, Harry (pseudo name). One week prior to the assessment, Harry had expressed a desire kill his parents by burning down his parents' home but stated he would not do it. Evaluating Harry using the criteria for imminent danger (within 24 hours), Shana believed Harry did not meet criteria and released him. The next day, Shana read in the newspapers about the burning of Harry's home, the death of his parents, and his arrest as the alleged arsonist.

Shana indicated she was now more likely to initiate a civil detainment as a precautionary tactic. Shana reported that her evaluations are more stringent than her peers in her organization are. Because of Harry's case, she has become extremely cautious about releasing any individual who voices threats of danger. The tragic experience has altered her evaluation criteria. The deaths of Harry's parents reinforced Shana's need to evaluate individuals who are being assessed for civil detainment under the strictest of criteria.

Through my use of the hermeneutic process, I found that other stakeholders validated experiences like Shana's. The mental health professionals affirmed that both personal and professional life experiences influenced the evaluation of dangerousness. Although not generalizable, the mental health professionals in this inquiry reflected similar beliefs that a clinician's interpretation of the criteria of dangerousness associated with his/ or her history with civil detainment experiences factors into making decisions about civil detainment (Alexius, Ajuefors, Berg, & Aberg-Wistedt, 2002; Engleman, Jobes, Berman, & Langbeing, 1998; Monahan et al., 1995). In spite of mandated training, CSB evaluators may continue to operate under a personal value-based interpretation of legislation that supports the Social Contract Theory.

www.manaraa.com

The safeguards in place within the legislation may not be protecting the individual's human rights resulting in civil right violations. The Commonwealth's lack of clear definitions for critical concepts such as 'dangerousness' and 'near future' created ethical issues experienced by all stakeholder groups. However, in an attempt to acknowledge the complexity of civil detainment, the Commonwealth established safeguards to ensure the protection of an individual's civil rights. However, in my inquiry, there were several examples of situations where the safeguards did not protect against civil rights violations.

One safeguard has been the process that allows the civil detainment order to be appealed. However, the appeal process has not always protected individuals with mental illness as designed. One judicial stakeholder described the problems with the implementation of safeguards using the following example. If the petitioner (the CSB employee) of a civil detainment believes the detainment is incorrect due to a re-examination of the criteria, the petitioner is unable appeal the CSB's decision per the legislation. The result is a potential civil liberties violation as the individual detained continues to be detained without sufficient evidence to support the removal of his or her right to liberty.

An additional problem with the safeguard is the ability of the individual detained to appeal his or her civil detainment order. This appeal must be completed within 10 days of the decision to detain the individual. To appeal the civil detainment, a series of documents are completed and filed with the Commonwealth Attorney's office. While the steps for appealing the civil detainment occur, the hearing for the civil commitment continues forward within the legal specified timeframe. The appeal of the civil detainment was never processed as the civil detainment hearing occurred prior to the appeal process being presented to the Commonwealth Attorney. In this example, the protection of rights did not occur.

www.manaraa.com

A second safeguard is the use of various professionals in the detainment hearing to decide as a group whether to detain the individual longer than the civil detainment period. This multi-disciplinary team approach is designed to ensure a fair hearing. With a wide variety of professionals discussing the individual who was detained and determining the extension of mandated treatment, it should be unusual for all individuals to be committed to the hospital. However, it was reported that, in one particular region of the state, a 100% detainment rate had occurred -- every person assessed was indeed committed. At the time of this inquiry, there was no system in place to evaluate and address the variances in the rate of commitments among judges so that information is unknown to me.

Another example of a legislative safeguard that did not protect individual rights concerns the right of the hospital administrator to void a civil detainment order. No interviewee in this inquiry was aware that this particular safeguard had been utilized. Rather, it was believed by participants that psychiatrists and administrators have been reluctant to question the civil detainment determinations prior to the civil detainment hearing because of liability issues. ... One interviewee shared a story of an individual detained and subsequently admitted to a psychiatric unit. However, he detained individual was determined to be without a mental illness and the interviewee believed the civil detainment was precipitated by a situational crisis rather than a mental illness.

This violation could have been prevented if the administrator of the hospital overrode the civil detainment order prior to the commitment hearing. In this case, the CSB evaluator had made a determination that the civil detainment criteria of mental illness and dangerousness were met. When the psychiatrist asserted that no mental illness existed (the first criterion), it brought into question whether dangerousness (the second criterion) was still an issue. However, the

www.manaraa.com

administrator was reluctant to act on the psychiatrist's diagnosis and dismiss the case prior to the civil commitment hearing because the administrator was concerned about liability issues and the community's safety. In other words, the only "out" was to elicit the hospital administrator's "pardon." However, administrators may hesitate to assume the liability of overturning a civil detainment order prior to the hearing for fear that the individual will do harm after the release.

Having two doctors who complete independent evaluations of the individual detained and support the administrator's decision to overturn the TDO may increase the use of this safeguard and may ensure the protection of an individual's civil rights.

The lack of usage in this inquiry for the imbedded safeguards available in the civil detainment legislation may suggest that the implied agreement of a social contract theory remains relevant in today's society as the community's right to safety trumped the individual's civil rights. No empirical research has been completed in the Commonwealth of Virginia pertaining to the use or lack of use of particular safeguards and yet due to the complexity of civil detainment, researching the lack of safeguard usage would be vital for policy makers and practitioners.

Needs for recovery.

Compassion offered once during the civil detainment process may increase the likelihood that dignity violations are forgiven. In this lesson, compassion or the absence of compassion is reflected in acts of caring, dismissive acts related to caring, and passive acts or not acting in a caring manner. Compassion, or the lack of compassion, was identified by each of the individuals with mental illness as the most crucial aspect to the experience of civil detainment. Although acts of compassion varied in type and intensity from person to person, forgiving dignity violations held true for all individuals involved in the civil detainment process. Fifty-four

www.manaraa.com

individuals may be involved in the process of detaining one individual. In cases where individuals experienced multiple violations of dignity, if the individual detained experienced but one act of compassion such as being treated as a human being, most other violations were forgiven.

Individuals detained experienced compassion in a number of ways such as being helped to calm down, having peer support, and having caseworkers and physicians who followed up on them while detained. Professionals who helped ensure smooth transitions during the various transfers from one stakeholder group to another were also thought to be compassionate. Specific examples of compassion included: "the police kept my husband calm," "people making you feel human," "arrangements [such as finding a hospital bed or facilitating a smooth hand-off to the CBS staff] were made," and one professional who allowed an individual to call "my mother in Ethiopia – allowing me to talk with her". Professionals who were able to slow the civil detainment process and offer direction and education were valued. Education offered by the professionals during the process increased the likelihood that individuals with mental illness would comply with the detainment order. The experience of individuals giving time beyond what was expected emerged as the most frequently shared example of caring and compassion.

Families described examples of individuals offering compassion such as others offering transportation to magistrates, friends typing up reports about the events leading up to civil detainment to assist the family in their argument for civil detainment, and taking time to listen to concerns and fears without judgment. Members of the family stakeholder group identified additional time offered by professionals and friends as a significant sign of compassion.

Acts of compassion attributed to first responders were non-tangible efforts to support a sense of independence, recognition, acceptance, advocacy, and empowerment. Examples

www.manaraa.com

included efforts "to find a bed," create methods of restraint that were less restrictive, or decisions "not to use handcuffs". Tangible efforts included buying clothes and food for the individual with mental illness, contacting friends and family for detained individuals, developing a short-term calming room for use without the need for restraint, and administering daily medications while providing breakfast daily to homeless individuals with mental illness. If my interpretation of the first respondents' efforts is correct, all are examples of promoting dignity as defined by Jacobson (2009).

Dismissive acts of compassion was also identified by multiple participants. Individuals with mental illness described dismissive acts as being called "crazy", not given medications for physical issues, and not offered a lawyer. One individual with mental illness reported being confused about her identity and she attempted to explain this confusion to the officer. She recalled the police officer declaring: "I will take you out back and kick you until you know who you are". A family member of one individual detained, in a dismissive manner stated when the individual with mental illness informed her that she had been detained, "Okay, Mom, let me know when you are out". When I asked for more detail, the individual with mental illness stated that her child had become callous to her situation and would no longer visit her at the hospital verbalizing a desire be uninvolved in her needs when it came to her mental illness. If you agree with my interpretation of the stakeholders' experience, you may find it reflective of the studies that found family members experienced a parent's mental illness as an almost unmanageable situation (Ahlstrom et al., 2010).

Families often identified CSB evaluators and judges demonstrating a lack of compassion. Participants reported that, "the judge was belligerent" or that a CSB worker on the phone said in a demeaning tone, "Oh yeah…..we've talked before". Dismissive acts of

www.manaraa.com

compassion included being told, "nothing can be done," not being heard, and projecting anger and boredom when conducting evaluations. Additional experiences reported were being ignored, discounted, and not having access to appropriate treatment.

Mental health professionals described dismissive acts such as "treatment teams being disrespectful" of the individual with mental illness, incidents in which "the family is left hanging" without information about their family members, and nurses being "for the most part, not compassionate" in their comments and actions. Often, the hospital system did not promote "privacy and dignity". Privacy violations included space being unavailable for family therapy sessions or evaluations resulting in meetings occurring in general population areas. Dignity violations included experiences of being physically restrained while other staff and patients being allowed to stand and watch the process. My case report reflecting dignity violations defined by participants as indifference, condescension, dismissal, disregard, restricting autonomy, labeling, and vilification appears similar to the literature (Baillie, 2007; Beauchamp & Childress, 2001; Jacobson, 2009; Prinson & vonDeldon, 2009; Sudak, Maxim, & Carpenter, 2008).

The experience of civil detainment is comprised of a series of contacts or hand-offs between individuals and organizations, i.e. the police will transfer the care of the individual detained off to the CSB prescreener who will then transfer the care of the individual detained off to the hospital, etc. The quality of these hand-offs appears critical to the positive experience of civil detainment. Each hand-off is critical as it presents another opportunity for acts of compassion or dignity violations. The case report reflected that loss or preservation of dignity has a significant impact on the emotional experience of civil commitment; similar to research on dismissive acts (Bay, 2006; Green, 1997; Hallaux, & Bray, 1990a; Katsakou & Priebe, 2007;

www.manaraa.com

Kallert, Blockner, & Schutzwoh, 2008; Loue, 2002; McFarland, Faulkner, Bloom, Pescosolido et al., 1999; Pescosolido et al., 2000; Reuland, Schwarzfeld, & Draper, 2009; Sartorius, 2004; Tanay, 2007). My lesson learned is that one encounter with a compassionate act, defined as compassionate by the receiver, is able to void multiple dismissive acts-suggests that the civil detainment experience is "person-dependent".

Individuals with mental illness may be willing to accept civil detainment as necessary to gain recovery. Most of the individuals with mental illness who I interviewed described a strong desire to remain free of the civil detainment experience. Civil detainment was perceived by many individuals with mental illness as focused primarily on the illness and less on the tenets of recovery. However, many participants expressed the desire to remain in a recovery-focused environment and saw civil detainment as a component of recovery (Appelbaum, 1988; Dubois, 2008).

More than one individual with mental illness acknowledged civil detainment as "a necessary evil" in his quest for recovery. Similar to the literature (Appelbaum, 1988; Dubois, 2008; Green, 1997; National Alliance on Mental Illness, 1995, Satcher, 1999), the individual's detained reported that the experience acted as a "braking system" to the illness that allowed him or her to recover from the illness. Individuals with mental illness acknowledged that without outside involvement such as the civil detainment, they would not have successful in their recovery attempt.

Mandated treatment fraught ethical dilemmas may act as a barrier to the success of the civil detainment experience, limiting recovery. In the literature, the lack of availability of hospital beds, mental health services funding limitations, and the restrictions with the policy limitations produced ethical dilemmas for many of those involved in civil detainment

www.manaraa.com

determinations (Alexius, Ajuefors, Berg, & Aberg-Wistedt, 2002; Engleman, Jobes, Berman, & Langbeing, 1998; Monahan et al., 1995). Similarly, my interpretations of the multiple perspectives were that stakeholders in this inquiry were experiencing comparable ethical struggles associated with locating bed space, alternative treatment modalities, and transportation to the civil detainment evaluations.

Any decision to mandate detainment of an individual must balance three ethical issues: patients' rights to liberty and dignity, patients' rights to receive medical care, and protection of the community (Zemishlany, 2007). More than one interviewee described the ethical quandary that emerges when access to treatment is denied due to a lack of bed space. The civil detainment policy states that an individual may not be detained beyond six hours. If the individual is deemed in need of mandated treatment but there is no bed space available, he or she is free to go after six hours. The civil detainment order (TDO) becomes invalid.

Participants in this inquiry shared experiences of time expiring on a civil detainment order before a bed in a psychiatric hospital could be located. Frustrations emerged as professionals searched for alternative approaches to the lack of bed availability. At times, evaluators refused to communicate to the individual detained that the civil detainment order had expired and he or she was free to leave. The result was that the individual with mental illness remained in the emergency room under false pretenses, receiving medication, incurring a medical hospital bill, and under the care of a medical staff that monitored safety issues. The individual's rights were not protected in this situation; however, he received care. Twenty-four hours later when a psychiatric bed became available, the individual was discharged from the emergency room, admitted to a psychiatric unit as an involuntary admission, and received treatment.

www.manaraa.com

Fear was palpable during the interviews when the participants shared concerns about the possible consequences to lack of treatment. In particular, participants described the deleterious effects that occur when individuals with mental illness are incarcerated for months without treatment. Two fears emerged related to lack of mandated treatment. The first fear was that the mental illness would become so exacerbated and intractable that recovery would not be possible. The second fear was that individuals with mental illness would commit suicide or kill their loved ones if treatment was not mandated. In other words, many participants believed that without treatment, their mental illness could and would worsen and become protracted, allowing them to become lost to recovery, either due to the permanency of the illness or death.

In the Commonwealth of Virginia, McGravey (2007) found difficulties with bed availability adequate for the continuum of services necessary for quality treatment, lack of funding for treatment, problems managing the inconsistencies between agencies, and minimizing the complications involved in transporting the individual detained to the designated facilities. In this inquiry, stakeholder groups identified similar struggles during the process of civil detainment. Struggles included a lengthy pre-screening process, inconsistent interpretation of the criteria for detainment, the extensive time required to complete the detainment process, and a lack of permanent solutions allowing multiple reoccurrences.

Social workers' have a dual responsibility to clients and to the broader society (NASW, 1999). This balancing of an individual's liberty and self-determination with society's need for safety while protecting the dignity of the individuals involved produces additional ethical dilemmas. An example of this potential ethical dilemma emerged when a Community Service Board required an outpatient mental health professional to bring the individual who needed assessment to the CSB's office. When the individual with the mental illness refused to be

www.manaraa.com

transported to the CSB, the mental health professional offered the individual 10 million dollars to comply with transportation. The outpatient professional, caught in an ethical dilemma, decided that lying was less egregious than allowing potential harm to occur to the individual and/or the community. The professional made the decision that the individual's need for treatment outweighed the moral imperative to be honest. This is the legal balancing test – is the danger to society great enough to justify the deprivation of liberty through deceit? In this case, the professional determined yes.

Hypotheses

There were three working hypothesis. The first hypothesis that was *different stakeholders would have multiple understandings of civil detainment and varying perspectives on the purpose of the new legislation*. All participants concurred that safety was the meaning of civil detainment. Yet the stakeholders had little information on the purpose of the new legislation; subsequently, their perspectives were significantly limited related to the legislation.

The second hypothesis stated *the experiences of civil detainment will vary reflecting the inconsistencies of the "policy-in-experience"*. Each interviewee described different experiences due to the inconsistencies of the "policy-in-experience".

The third and final working hypothesis was *the meaning of civil detainment will depend on the stakeholders' perspective on recovery, dangerousness, and dignity contextual to the experience of detainment*. The meaning of civil detainment was clearly interpreted as safety. Safety centered on recovery and dangerousness. Dignity did not appear to be a component of the meaning of civil detainment but rather significant in the experience of civil detainment. The variance emerged not in the meaning of civil detainment but in the individual's experience of civil detainment related to perspectives on recovery, dangerousness and dignity by not only

www.manaraa.com

him/herself but also by the other stakeholders in the process who influenced the overall experience.

Implications

My inquiry uncovered a number of issues and questions that would benefit from a re-examination of policies and further research about civil detainment. If my interpretation and case report is accurate, my lessons learned lead me to recommend legislative changes to address and clarify terminology such as "danger," "safety," "near future," and "imminent future". Clarification may reduce the inconsistencies that the new policy was designed to eliminate; thereby, increasing the ability to offer a humane dignified civil detainment process. Concurrent with the reduction of inconsistencies, human rights violations may also be reduced. An example of this could be an additional criterion that the individual with mental illness would have committed an act of danger towards self or others in the last 12 months.

Policy Implications. The experience of civil detainment is a complex phenomenon further complicated by legislation that is not uniformly applied in the Commonwealth of Virginia. Given the lack of congruence between the policy's intent and its implementation, civil detainment legislation does not appear to provide the guidance necessary to implement the policy uniformly.

Policy changes that occurred in July 2008 are misunderstood and perhaps other policies would be more appropriate to minimize inconsistencies in the application of the legislation. To address the lack of congruence between the policy's intent and its implementation, additional guidance could be offered or mandated to all professional stakeholders regarding the intent of the policy to preserve human dignity, the safeguards that were established to ensure civil rights and the need for surveillance over the implementation of the policy. These efforts may offer a way to

www.manaraa.com

ensure the uniform application. Without the uniform application of the law, individuals' rights may not be protected.

In addition, the policy of civil detainment has been a state policy requiring community level implementation with regard to the resources and unique cultures within each of these communities. The varied resources and unique cultures produce inconsistencies in the availability of alternative treatment services designed to treat the individual with mental illness in the least restrictive environment. Individuals with mental illness, families, and communities are paying the price of the negative impact that varied resources have on equitable access to proper treatment. The Commonwealth of Virginia's legislation § 37.2-504 mandates that the CSB's offer case management and emergency services and ensures that funding is available (Code of Virginia, 2012b). Other services such as crisis stabilization units or drop in centers are not guaranteed funding (Virginia Association of Community Services Boards, 2012). These services are supplemented by variety of funding sources such as fees, grants, federal funds, and local matching (Virginia Association of Community Services Boards, 2012).

If funds are not sufficiently appropriated to provide mental health treatment in the least restrictive environment, the individual with mental illness may not receive quality care. Funding not appropriated evenly across all localities limits the uniformed application of services (Hudson, 2012). One possible step to rectifying this would be to conduct a thorough analysis of services throughout the Commonwealth and redistribute the resources regardless of county lines.

To improve mental health services, the local authorities may need to release a portion of power and alter their fiscal practices. This moving of authority and power would allow the state government to establish a full range of services to support the individual with mental illness in his or her recovery not withstanding his locality of residence. This distribution of resources

www.manaraa.com

evenly across the Commonwealth of Virginia may result in a potential decrease in the number of inconsistencies for the policy-in-experience (Hudson, 2012). Shifting authority to the state level of government may create also additional issues; however, the uniform application of the policy may protect the rights of citizens more thoroughly.

Funding for CIT training appears to be inadequate throughout the Commonwealth. The Commonwealth of Virginia may benefit from policies pertaining to the allocation of funding for CIT training related to mental illness. An example of the issues related to funding is illustrated in the implementation of CIT training. This CIT training, identified in this inquiry as vital and valuable to the positive experience of civil detainment, is available in only 23 out of 135 counties or cities in the Commonwealth (NAMI, 2011). Even within these 23 municipalities, funding only permits 25% of the officers to receive CIT training. This leaves 75% or more of the police officers in 23 out of 135 counties vulnerable to misunderstandings about individuals with mental illness resulting in potential dignity violations. Lack of funding also leaves the remaining 112 counties and cities without any CIT training.

In this inquiry, CIT trained professionals are enthusiastic about the CIT training's benefits. Given that CIT training appears to have a positive impact on the civil detainment experience, everyone may benefit from more funding to support this program across the entire Commonwealth. Participants report that funds are not able to match the demand; the result is a lack of growth and expansion of CIT training. Given that, CIT training appears to be crucial in the improvement of police response to situations involving individuals with mental illness and for the training of CSB evaluators (Compton, Bahora, Watson, & Oliva, 2008; Geller, 2008; Morrissey, Fagan, & Cocozza, 2009). Policies related to training social worker practitioners

www.manaraa.com

other professionals such as emergency room personnel, rescue squad staff in CIT would be advantageous.

A uniform application of the civil detainment policy may reduce the stigma that remains related to mental illness. NAMI (2012) has taken a powerful stance related to policy development through efforts of lobbying and ensuring that consumers are included in the development of policy. Extending NAMI's efforts to increase the number of consumers involved in policy development may increase the sophistication of policies pertaining to individuals with mental illness and their families.

A number of additional policy recommendations emerged from this inquiry.

1. The experience of civil detainment would be enhanced by efforts to advance policies supporting parity for health care coverage for mental illness.
2. An increased ability to establish and sustain additional psychiatric bed availability would improve the overall experience of civil detainment.
3. It would be valuable to have a system that monitors and addresses statistical outliers such as judges with 100% detainment/commitment rates in order to protect civil rights.
4. Civil rights may be protected further if a surveillance system, such as quality assurance, was established to monitor specific aspects of the civil detainment experience; such as the percentages of discharges prior to the civil commitment hearing as it relates to municipality or the percentages of civil detainment appeals that were "heard" prior to the civil commitment hearing.

Finally, a re-examination of the policies designed to protect individuals with mental illness may be in order. Policies designed to protect individuals, such as Health Insurance

www.manaraa.com

Portability and Accountability Act (HIPAA), may be buttressing stigma. In a culture, that isolates mental health treatment, extensive and interlocking efforts are needed to decrease stigma and facilitate mental health and mainstream medical treatment. In other words, efforts to protect an individual's privacy as it relates to mental illness may be maintaining fear with those individuals kept away by the privacy afforded individuals with mental illness.

Practice Implications. The experience of civil detainment does not happen to just the individual with mental illness. The experience also affects social work practitioners and professionals who are responding to crises, struggling to determine the most appropriate level of care, creatively organizing limited resources, and coping with their responsibility in the loss of life of clients and the exacerbation of the mental illness when their interventions are unsuccessful.

The role of social work practitioners, mental health professionals, and first responders involved in maintaining dignity and offering compassion during the experience of civil detainment for the individuals detained and the families emerged as a central theme throughout my inquiry. Individuals in these stakeholder groups have unlimited power to "make or break" the experience of civil detainment. The participants in this inquiry described the importance of presence and caring, defined as "the use of self to convey a deep sense of availability to the patient" (Olofsson & Jacobsson, 2001, p.364). Social work practitioners and other stakeholders sharing their experiences of civil detainment to peers, organizations, and/or the public may develop collaborative opportunities to educate and enhance others' understanding of the subjective experience of the individual with mental illness (Borg & Kristiansen, 2004; Kowlesser & Corbett, 2008; Pitt & Kilbride, 2006).

www.manaraa.com

Sharing stories helps others to understand mental illness and decrease the stigma (NAMI, 2011) and may further advance professionals' understanding of the experience of having a mental illness. The inquiry revealed that stakeholders reported a benefit from the opportunity to discuss their experiences. Individuals with mental illness experienced this sharing as a means for maintaining and recapturing his or her dignity. Known as validation catharsis, individuals may gain a sense of personal control through becoming a consumer educator, an important factor in recovery (Borg & Kristiansen, 2004; Kowlesser & Corbett, 2008; Pitt & Kilbride, 2006).

As indicated in the literature and the lessons learned, the medical model and recovery model are based on divergent philosophies about who should be in charge of medical decisions and produces conflicting results in terms of autonomy and recovery (Bransford 2011). These conflicts have the potential to produce rifts among advocates of the medical model and advocates of the recovery model (Jacobson & Greenley, 2001). Perhaps the best alternative would to explore and research ways to develop a third model of care that combines the unique strengths of each model and increases shared decision making (Peterson, 2012).

CIT training may be one way to increase professionals' ability to be sensitive to policies that may result in negative consequences. During this inquiry, CIT trained officers reported an advantage. The new communication skills garnered by the specialized CIT training allowed them to be better equipped to manage potential consequences to detaining an individual with mental illness. Through CIT training, CIT-trained officers were able to translate "mental health talk" into "cop talk" that other police officers may understand. This kind of translation helped the CIT-trained police officers explain the subjective experiences of mental illness to other police officers.

www.manaraa.com

A more empathetic view of individuals with mental illness and an enhanced understanding of treatment needs resulted in an alteration in practice. Ongoing, standardized CIT training of all stakeholders involved in the process of civil detainment would aid in development and sustainment of a common language. A common language proved to be helpful in the stakeholders who had received CIT training, would improve the overall civil detainment experience, and may lead to new standards of practice for all stakeholders.

It is also critical that social work practitioners and mental health providers who implement civil detainment have a clear understanding of their personal and professional values and priorities about individuals with mental illness (Comartin, 2011). Ensuring that values and priorities are considered during policy development can unambiguously extend future policies and practices. In this inquiry, I found that professionals who are trained to protect the vulnerable used pejorative language toward individuals with mental illness and their families. If professionals undergo an honest examination of their values and prejudices, this may increase their ability to advocate for change instead of creating obstacles. Such an examination may also decrease the use of judgmental language that supports stigma in the mental health community more so than the medical community does.

Recently, a friend of mine entered into a local hospital for a 16-hour procedure to correct a medical condition. The surgery was extensive and complicated. I took her to the facility and sat with her as she waited for admission. After the nurses began the process of the initial preparations for surgery, I was allowed to sit with her until she was taken into the operating room. I then waited in the lobby, read books, visited with others, drank soda, and every four hours, the surgeon called from the operating room giving me reports of his progress and my friend's medical stability. At midnight, the surgery was completed. The physician came to the

www.manaraa.com

lobby to offer me a description of the surgical procedures, her present condition, and her prognosis for the future.

I then met my friend on the medical floor at 1:00 AM where she was admitted for the night. With my understanding of a hospital's operations, I was aware that nursing staffing ratio had declined due to multiple issues. I knew that my friend was in a vulnerable position and unable to advocate for herself. For these reasons, I stayed overnight with my friend for her entire hospital stay. The staff allowed me to remain in her room. I would shower in the morning and leave for work while another friend arrived to stay with her throughout the day.

During the days that followed, she would go for physical therapy, x-rays, etc. I witnessed, supported, and advocated for her care. I was also able to be supportive and provide my friend with clarification about the treatment procedures ordered by the doctor. For the most part, my friend maintained the majority of her autonomy; the staff maintained their dignity and reciprocated with dignity.

I wondered about the obstacles in place that limit such an experience to be offered to an individual with mental illness in the hospital. The individual is detained and scared; he or she needs support, education, and an advocate. How would the experience of civil detainment be different for the individual with mental illness was afforded similar rights; rights that we afford individuals with physical illnesses? Although there are differences in the two conditions, does it justify the vast disparities in the way individuals with mental illness are treated? Social work practitioners and mental health providers have the ethical responsibility of providing treatment that is fair and equitable (DiFranks, 2008). Use of peer advocates may be one way to decrease the disparities that individuals and families experience during the civil detainment experience.

www.manaraa.com

Throughout my inquiry, I was constantly amazed at my own ignorance about the nuances and complexities of the experience of civil detainment. Likewise, if the other professionals and stakeholders involved in the process reflected on their role and personal biases, it may increase the ongoing critical analysis of current policies and enhance the value of civil detainment for individuals with mental illness. Utilizing a positive health paradigm, social work practitioners and other professionals could utilize the strength-based approach in all aspects of policy analysis and development (Wand, 2012).

Implications for the Social Work Profession. If the meaning of civil detainment is similar to the weaving of a basket, then a steady hand is needed to weave an experience of civil detainment that is dignified, caring, strong, and effective. With basket weaving, one weaver completes the basket ensuring the product is created according to the plan. With one weaver in charge, consistency may be accomplished in the actual creation of the basket.

However, many different people are involved in the process of civil detainment. Currently, the individual detained may be "handed off" to as many as nine different stakeholder groups prior to the commitment hearing. Social workers, governed by the "person-in-environment" principle (Dwane, 2011) are trained to examine the multiple factors influencing a situation and remain focused on the individual in his or her environment. These skills position social workers to assume the role of the basket weaver with the skills necessary to transverse the multiple "hand-offs".

Social workers are positioned to advocate (McLaughlin, 2009) for peer support processes that assign a peer advisor to "walk with the individual" who is being detained. This may facilitate a humane and dignified detainment process giving the detained individual a sense of protection. Peer support would also aid the phenomenon of "presence", which has been

www.manaraa.com

identified as critical for treatment (Olofsson & Jacobsson, 2001). Utilizing peer support may be one way to increase the consistency that the policy was designed to obtain.

Promoting and supporting opportunities for dignity and decreasing dignity violations emerged as paramount to improving the experience of civil detainment. Dignity may be enhanced if social work practitioners move away from the medical model of care and move towards developing a new model of care that is more inclusive of multiple perspectives. Examining alternative ways to conceptualize mental illness, recovery, and dignity may produce a model of care that promotes dignity, respects the biological component to mental illness, ensures the inclusion of the medical professions expertise, and includes a strong recovery focus.

Social work professionals have the moral obligation to advocate for social justice for vulnerable populations (McLaughlin, 2009). In this inquiry, individuals with mental illness and families were found to be more vulnerable than other stakeholder groups, such as mental health professionals, first responders, and judicial professionals, as they lack authority in the civil detainment system. Social work professionals are positioned to advocate for social justice issues such as the lack of parity in insurance benefits, the additional stressors placed on families of individuals with mental illness, and the provision of more days off for family and friends who care for individuals with mental illness (McLaughlin, 2009).

In addition, a social workers' mission is to advocate for policies that protect the vulnerable human being. This protection includes undue indignities during "hand offs." Policy changes may allow one individual social worker to become the weaver responsible for following the individual with mental illness through his or her experience with the civil detainment process. Protection includes advocating for a more holistic and healing civil detainment

www.manaraa.com

experience (McLaughlin, 2009). This type of policy change may also protect the dignity of all the individuals involved in civil detainment.

Social workers have both positional power and referent power. The field of social work is innately political and all about power" (Hugman, 1998 cited in Bar-On, 2002, p.998). This power increases the social worker's capacity for gaining access into organizations through collaborative professional relationships (Lauby 2010). Developing a collaborative relationship with organizations may aid in the identification of educational opportunities. My inquiry revealed that lack of knowledge about the new legislation is not confined to individuals with mental illness. All stakeholder groups were ignorant about the nuances of the civil detainment legislation. One result of this ignorance may be an inability to protect an individual's civil rights and the subsequent overlay of personal values incongruent with the intent of the legislation. If more social workers join voices with the voices of individuals detained, NAMI, peer support groups, families, and hospital staff, it may extend a recovery-focused model of care that promotes civil rights.

Social workers have unique training to examine conflicting values from multiple angles and understand the individual and the environmental forces "at play." Knowledge of the legislation and understanding the experience of the stakeholders increase a social worker's ability to maintain a balanced perspective (Rodgers, 2010). This critical understanding enhances empathy and awareness of the influences affecting decision points within civil detainment for the individual and professionals involved. The inquiry identified that following the legislation of civil detainment without the use of personal judgment results in procedures that reflect a "one shoe fits all mentality". This may not always the best approach. Conversely, it also became

www.manaraa.com

apparent that remaining true to the criteria of the legislation and not interjecting one's own personal values might increase the consistency of outcomes.

Social workers can play a critical role in decreasing the isolation felt by families and assisting families combat the negative effects of stress on their physical health. Additionally, social workers can cultivate relationships with magistrates, local police, psychiatrists, mental health facilities, and CSBs to increase the understanding and support offered by professionals to individuals and families. Through developing coalitions that focus on improving the process of civil detainment for all stakeholders involved, the overall experience of civil detainment may be greatly enhanced.

Social Work Education. The curricula for all types of social work degrees, whether it is a B.S.W., M.S.W., or Ph.D., would benefit from information about the multiple perspectives of the individuals involved in this inquiry. In order for social workers to be able to engage in addressing the multiple issues that emerged related to civil detainment, the schools of social work need to address civil detainment from both a macro and a micro perspective (Mirabito, 2011). Values and perspectives in policy development (Stone, 2002) are important elements to ensure that social work students understand. Additionally, training to utilize critical thinking, negotiating skills, and analysis skills should be offered to social work students who have chosen to do policy work as well as those students who will be providing direct services.

Social work students who will be providing direct services need to be cognizant that clinical skills such as active listening, probing questions, and use of conflict are all necessary skills in policy development, policy implementation and policy analysis. Equipping social work students with the expertise to address the complex process of civil detainment would aid in the promotion and impact of a holistic understanding of the civil detainment experience (Mirabito,

www.manaraa.com

2011). . In particular, social work students would benefit from a critical analysis of *all* stakeholders' perspectives, not just the perspective of the individual detained.

The Need for Research

My interpretation of the inquiry data resembles the results of JLARC (1997) and McGravey (2007). All three studies revealed similar issues of stigmatization, inconsistencies in the application of the law, and human rights violations. Social work research is primed for investigation of these areas. Although it had been four years since the 2008 legislation, numerous problems may remain, including inconsistencies of policy application, lack of available beds, a need for alternative services, and the necessity for further education. Given the possible problems that may remain, research that investigates the barriers to change is critical.

Nonetheless, there had been small signs of progress, such as CIT training, uniform training for CSB evaluators, and improvements in the appropriate application of civil rights. However, research is a vital component to improvements as debates in the literature on the efficacy of mandated outpatient treatment (Bonnie & Monahan, 2005; Pescosolido, et al., 1999; Watson, et al., 2005) continue. In addition, the debate about the need for surveillance of individuals with mental illness remains ongoing in the media (Jaffee, 2011; Lightfoot, 2011).

Unfortunately, there has been minimal investigation around the effectiveness of interventions used such as CIT or peer advocates. Additional research could evaluate the success of programs such as CIT, drop-in facilities developed and run by individuals with mental illness or peer-to-peer training (NAMI, 2012). Other potential inquiries could include assessing the effectiveness of mandated outpatient treatment; clarifying the relationship between the criminal justice system and the mental health system; and examining the barriers to increasing bed capacity in psychiatric facilities. Further studies may also uncover additional political and financial

www.manaraa.com

pressures diverting funding away from mental health services. With the identification of such pressures, lawmakers would be better equipped to re-examine policies and redistribute funds to meet the identified needs. In addition, research could examine the needs of geriatric patients with mental illness as well as the child and adolescent populations' experience of civil detainment.

A reexamination of the implementation and utilization of the civil detainment legislation may be in order. There have been a number of policies within the legislation that have not been fully implemented. For example, policy §37.2-813 has allowed a detained individual to be released by the director of the facility prior to the commitment hearing (Code of Virginia, 2012). Anecdotal data from my inquiry suggests this authority has never been invoked. Further examination may discover how often and under what conditions this policy has been implemented, the positive and negative impact of its application, and stakeholders' perception of the policy.

Another area of needed research is the exploration of the relationship between attributions of responsibility for mental illness and dignity violations. Professionals regularly involved in commitment proceedings, particularly emergency room staff, could be oversampled in future studies to gain a better understanding of their attitudes relating to compassion and presence. Researching the behaviors and beliefs of individuals within hospitals, police systems, and in emergency departments pertaining to individuals who are being detained could help inform training and lend support for additional changes. Research focused on compassion, the implications to individuals who have been detained, and the professionals involved may aid in the development of policies that would decrease dignity violations.

www.manaraa.com

My inquiry revealed opportunities for further examination such as how is the determination of a civil detainment determination altered by 'expertise bias'? What is the percentage of geriatric patients needing civil detainment in the Commonwealth of Virginia but not receiving appropriate care and treatment? Finally, how does the behavior of police dispatchers who have had CIT training compare with police dispatchers who have not received the CIT training in relation to the families' perception of dignity?

As indicated earlier, one of the limitations of this inquiry was that each of the individuals with mental illness detained was committed into treatment. Exploring the experience of being detained for a period of 4 to 6 hours and then being released is another area of needed research. More interpretive, this research could focus on the meaning and the process of detainment without any involvement with mandated treatment.

This inquiry did not isolate factors such as culture, race, and age. It may be that the cultural dimensions significantly alter the understanding of mental illness, danger and the ability to predict danger. Research that is conducted in a different paradigm that examines the potential impact of these variables on the civil detainment experience would extend our knowledge about civil detainment (Anglin, Link, & Phelan, 2006 & Arboleda–Florez, 1998).

Future Research. It has been four years since the 2008 legislation. Numerous problems may remain, including inconsistencies of policy application, lack of available beds, a need for alternative services, and the necessity for further education. Given the possible problems that may remain, research that investigates the barriers to change is critical.

Although beyond the scope of this study, it would be interesting to assess how the behavior of police dispatchers who have had CIT training compare with police dispatchers who have not received the CIT training in relation to the families' perception of dignity. Another area

www.manaraa.com

with little research is the impact of for-profit hospital agencies on the frequency of dismissals of civil detainments prior to ongoing mandated treatment. Aspects of supervision and what social workers in the capacity of first responders deem helpful would also be enlightening to explore.

Research could also evaluate the effectiveness of crisis stabilization units established in the last four years. Other potential inquiries could include assessing the effectiveness of mandated outpatient treatment; clarifying the relationship between the criminal justice system and the mental health system; and examining the barriers to increasing bed capacity in psychiatric facilities. Further studies may also uncover additional political and financial pressures diverting funding away from mental health services. With the identification of such pressures, lawmakers would be better equipped to re-examine policies and redistribute funds to meet the identified needs.

Conclusions

This constructivist inquiry explored the phenomenon of civil detainment from the multiple perspectives involved. This inquiry began with proposing that the theoretical framework of social contract theory underpinned the civil detainment legislation. Both social contract theory and the civil detainment legislation are based on a belief that individuals with mental illness are vulnerable and must be cared for by others resulting in a loss of liberty due to their illness. My inquiry found that in addition to the influence of the implied social contract, the multiple stakeholders' perspectives on safety heavily influence the ability of the policy to be consistently implemented.

Stakeholders have the power to enhance the possibilities for experiences of human dignity and must be vigilant to the possibility of committing dignity violations. The literature suggests that the criteria for civil detainment are fraught with inconsistent definitions, a myriad

www.manaraa.com

of variables, and influenced by misconceptions (Alexius, Ajuefors, Berg, & Aberg-Wistedt, 2002; Appelbaum, 2002; Appelbaum, 2008; Engleman, Jobes, Berman, & Langbeing, 1998; McGravey, 2007; Monahan et al., 1995). According to my interpretation of the 25 experiences examined in this study, the experience of the civil detainment in Virginia is influenced by similar factors such as misconceptions and inconsistencies in the definition of 'danger' and 'near-future'.

While individual participants' values and beliefs differed, civil detainment experiences are often based on the involved individuals' personal and professional perspectives. My inquiry's case report suggests that stakeholders agree on their understanding of the definition of mental illness, but they have multiple understandings of "near future" and are confused about how to predict future dangerousness. There is also a lack of consensus of the definition of dangerousness in relation to civil detainment. This lack of uniform understanding leads to inconsistencies in the implementation of the civil detainment policy and the potential violation of an individual's civil rights.

The underlying theory of an implied social contract continues to be a strong force that affects the civil detainment process. I would argue that the theory explains the prevalence of the medical model, the continued use of legislation in spite of the multiple ambiguities experienced by the individuals involved, and the recent loosening of the criteria that allows for a greater potential for civil detainments in the Commonwealth of Virginia.

The recommendations I make in this inquiry invite all stakeholders to participate in the clarification of laws, the advancement of education and training, and the advocating for changes to the processes that support, protect, and care for vulnerable populations. My inquiry suggests that policies and practices should change to address the cavernous cracks in a system that

www.manaraa.com

services an extremely vulnerable population. My hope is that additional research – utilizing many different research methodologies – is conducted in order to assimilate the complexities and subtleties of the phenomenon of civil detainment in the Commonwealth of Virginia to address the fractured civil detainment process.

"The important thing is not to stop questioning." Albert Einstein

www.manaraa.com

References

Ackermann, E. (2009). Piaget's constructivism, Papert's constructionism: What's the difference? *Psychotherapy*, *5*(3), 1–10.

Ahlstrom, B., Sharsater, I., & Danielson, E. (2010). The meaning of major depression in family life: The viewpoint of the ill parent. *Journal of Clinical Nursing*, *19*, 284–293.

Alexander, P., Neimeyer, R., Follette, V., Moore, M., & Harter, S. (1989). A comparison of group treatments of women sexually abused as children. *Journal of Consulting and Clinical Psychology*, *57*, 479–483.

Alexius, B., Ajnefors, L., Berg, K., & Aber–Wistedt, A. (2002). The decision making process including assessment of ethical principles in the commitment of police referred psychiatric patients. *Psychiatry Law & Ethics*, *21*, 107–119.

Alia–Klein, N., O'Rourke, T., Goldstein, R., & Malaspina, D. (2007). Insight into illness and adherence to psychotropic medications are separately associated with violence severity in a forensic sample. *Aggressive Behavior*, *33*, 86–96.

American Academy of Child and Adolescent Psychiatry. (2001). Normal adolescent development, part 1. *Facts for Families.* Retrieved from http://www.aacap.org/cs/root/facts_for_families/normal_adolescent_development_part_i.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Amerongen, D., & Cook, L. (2010), Mental illness: A modern day leprosy? *Journal of Clinical Nursing*, *27*, 86–90.

www.manaraa.com

Amore, M., Menchetti, M., Tonti, C., Scarlatti, F., Lundgren, E., Esposito, W., & Berardi, D. (2008). Predictors of violent behavior among acute psychiatric patients: Clinical study. *Psychiatry and Clinical Neurosciences*, *62*, 247–255. doi:10.1111/j.1440-1819.2008.01790.x.

Anfang, S., & Appelbaum, P. (2006). Civil commitment: The American experience. *Israel Journal of Psychiatry and Related Sciences*, *43*, 209–218.

Angermeyer, M. C., Corrigan, P. W., & Matschinger, H. (2004). Familiarity with mental illness and social distance from people with schizophrenia and depression: Testing a model using data from a representative population survey. *Schizophrenia Research*, *69*, 175–182.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatrica Scandinavica*, *113*, 163–179.

Angermeyer, M. C., & Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science Medicine*, *43*, 1721–1728.

Angermeyer, M. C., & Schulze, B. (2001). Reinforcing stereotypes: How the focus on forensic cases in news reporting may influence public attitudes towards the mentally ill. *International Journal of Law and Psychiatry*, *24*, 1–19.

Angermeyer, M. C., Schutze, B., & Dietrich, S. (2003). Courtesy stigma: A focus group study of relatives of schizophrenia patients. *Social Psychiatry and Psychiatric Epidemiology*, *38*, 593–602.

www.manaraa.com

Anglin, D., Link, B., & Phelan, J. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services, 57*, 857–862.

Appelbaum, P. (1988). The new preventive detention: Psychiatry's problematic responsibility for the control of violence. *American Journal of Psychiatry, 145*, 779–784.

Appelbaum, P. (1992). Involuntary commitment from a systems perspective. *Law and Human Behavior, 16*, 61–74.

Appelbaum, P. (2002). An American perspective: Paul S. Appelbaum: In conversation with Sameer P.Sarkar. *The Psychiatrist*, 26: 305-309 doi: 10.1192/pb.26.8.305.

Appelbaum, P. (2003). The "quiet" crisis in mental health services. *Health Affairs, 22*, 110–116.

Appelbaum, P. (2006). A history of civil commitment and related reforms in the United States: Lessons for today. *Developments in Mental Health Law, 25*, 13–22.

Appelbaum, P. (2007). Assessing competence to consent to treatment. *New England Journal of Medicine, 357*, 1834-1840.

Appelbaum, P. (2008a). A fool for a client? Mental illness and the right of self-representation. *Psychiatric Services, 59*, 1096–1098. Retrieved from http://psychservices.psychiatryonline.org/.

Appelbaum, P. (2008b). Privilege in the federal courts: Should there be a "dangerous patient exception"? *Psychiatric Services, 59*, 714–716. Retrieved from http://psychservices.psychiatryonline.org/.

Appelbaum, P. S., Appelbaum, B.C., & Grisso, T. (1998). Competence to consent to voluntary psychiatric hospitalization: A test of a standard proposed by APA. *Psychiatric Services, 49*, 1193–1196.

www.manaraa.com

Appelbaum, P. S., & Grisso, T. (1988). Assessing patients' capacities to consent to treatment. *New England Journal of Medicine, 310,* 1635–1638.

Appleby, L., Desai, P., Luchins, D., Gibbons, R., & Hedeker, D. (1993). Length of stay and recidivism in schizophrenia: A study of public psychiatric hospital patients. *American Journal of Psychiatry, 150,* 72–76.

Appleby, L., Mortensen, P. B., Dunn, G., & Hiroeh, U. (2001). Death by homicide, suicide, and other unnatural causes in people with mental illness: A population-based study. *Lancet, 358,* 2110–2112.

Arboleda–Florez, J. (1998). Mental illness and violence: An epidemiological appraisal of the evidence. *Canadian Journal of Psychiatry, 43,* 989–996.

Arehart–Treichel, J. (2007). Psychiatrists describe involvement with civil-commitment proceedings. *Psychiatric News, 42*(16), 12.

Ascher–Svanum, H., Faries, D., Zhu, B., Swartz, M., & Swanson, J. (2006). Medication adherence and long-term functional outcomes in the treatment of schizophrenia in usual care. *Journal of Clinical Psychiatry, 67,* 453–460.

Bachrach, L. (1980). Is the least restrictive environment always the best? Sociological and semantic implications. *Hospital & Community Psychiatry, 31,* 97–103.

Baillie, L. (2007). Patient dignity in an acute hospital setting: A case study. *International Journal of Nursing Studies, 46,* 23–37.

Bar-On, A. (2002). Restoring Power to Social Work Practice. *British Journal of Social Work,* 32, 997-1014.

Barak, A. (1993). *Supreme Court Justice of Israel. A constitutional revolution: Israel's Basic Laws, address at the University of Haifa (May 18, 1992)*. 4 Const. F. 82, 83.

www.manaraa.com

Bauer, A., Gruszniewski, A., Khawaled, R., Grinshpoon, A., Mark, M., & Mester, R. (2002). Reflections on dangerousness and its prediction: A truly tantalizing task? *Medicine and Law*, *21*, 495–520.

Bay, M. (2006). Making the law match the reality; Making the reality match the law. *Journal of Ethics in Mental Health*, *1*(1).

Beauchamp, T., & Childress, J. (2001). *Principles of biomedical ethics* (5th ed.). New York, NY: Oxford University Press.

Beck, C. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*, 263–266.

Beveridge, A. (1998). History of psychiatry: R. D. Laing revisited. *Psychiatric Bulletin*, *22*, 452–456.

Binder, R. (1999). Are the mentally ill dangerous? *Journal of American Academy of Psychiatry and the Law*, *2*, 189–201.

Bloom, J. (2004). Thirty-five years of working with civil commitment statutes. *Journal of the American Academy of Psychiatry and the Law*, *32*, 430–439.

Bonnie, R. (2006). *Opening Remarks Commission on Mental Health Law Reform*. Retrieved from http://www.courts.state.va.us/programs/cmh/background/2006_10_2007_06_bonnie_combined_opening_remarks.pdf.

Bonnie, R. (2007). *Letter to Chair: Commonwealth of Virginia Commission on Mental Health Reform*. Presentation to the Virginia Tech Review Panel. Retrieved from http://www.courts.state.va.us/programs/cmh/background/2007_07_bonnie_statement_tech_panel.pdf.

www.manaraa.com

Bonnie, R., & Monahan, J. (2005). From coercion to contract: Reframing the debate on mandated community treatment for people with mental disorders. *Law and Human Behavior, 29*, 485–503.

Bonnie, R., Reinhard, J., Hamilton, P., & McGravey, E. (2009). Mental health system transformation after the Virginia Tech tragedy. *Health Affairs, 28*, 793–804.

Bradshaw, W., Roseborough, D., & Armour, M. (2006). Recovery from severe mental illness: The lived experience of the initial phase of treatment. *International Journal of Psychosocial Rehabilitation, 10*, 123–131.

Bransford, C. (2011). Reconciling paternalism and empowerment in clinical practice: An intersubjective perspective. *Social Work, 56.*33-41.

Brakel, S., Samuel, J., & Rock, R. (1985). *The mentally disabled and the law.* Chicago, IL: University of Chicago Press.

Brockington, I., Hall, P., & Levings, J. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162*, 93–99.

Brooks, R. (2012). Psychiatrists' opinions about involuntary civil commitment: Results of a national survey *Journal of the American Academy of Psychiatry and the Law* 35:219-228.

Brown, J. S., Collins, A., & Duguid, P. (1989). Situated knowledge and the culture of learning. *Educational Researcher, 18*, 32–42.

Burrell, G., & Morgan, G. (1979). *Sociological paradigms and organizational analysis.* London, UK: Heinemann.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment* 6, 65-72 retrieved from: doi: 10.1192/apt.6.1.65.

www.manaraa.com

Center for Mental Health Services. (2001). *Annual report to Congress on the evaluation of the Comprehensive Community Mental Health Services for Children and Their Families program, 2001.* Atlanta, GA: ORC Macro.

Centers for Disease Control and Prevention. (2005). *U.S.A. suicide: 2005 official final data*. Retrieved from http://www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-142.pdf.

Chen, H. (2010). Mediation approach: Representing clients with mental illness in civil commitment proceedings. *Georgetown Journal of Legal Ethics*. Retrieved from http://fiindarticles.com/p/articles/mi_qa3975/is_200607/ai_n17185865.

Code of Virginia, (2012). Mental illness. Retrieved from http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-100.

Code of Virginia, (2012b). Community services boards; local government departments; powers and duties. Retrieved from http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-504

Cohen, B., Bonnie, R., & Monahan, J. (2008). *Understanding and applying Virginia's new statutory civil commitment criteria*. Retrieved from http://www.dmhmrsas.virginia.gov/OMH-MHReform/080603Criteria.pdf.

Cohen D, Crabtree B. "Qualitative Research Guidelines Project." July 2006. Retrieved from http://www.qualres.org/HomeCons-3824.html.

Comartin, E. (2011). Dissonance between personal and professional values: Resolution of an ethical dilemma. *Journal of Social Work Values and Ethics,* 8, 2-14.

www.manaraa.com

Commission on Mental Health Law Reform. (2008). *Progress report on mental health law reform*. 1-83. Retrieved from http://www.courts.state.va.us/programs/cmh/2008_1222_progress_report.pdf.

Compton, M., Bahora, M., Watson, A., & Oliva, J. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. American Academy of Psychiatry Law. 36,47-55.

Cook, J. A., & Razzano, L. (2000). Vocational rehabilitation for persons with schizophrenia: Recent research and implications for practice. *Schizophrenia Bulletin, 26,* 87–103.

Cooper–Patrick, L., Powe, N., Jenckes, M., Gonzales, J., Levine, D., & Ford, D. (1997). Identification of patient attitudes and preferences about treatment of depression. *Journal of General Internal Medicine, 12*, 431–438.

Copeland, D. (2007). Conceptualizing family members of violent mentally ill individuals as a vulnerable population. *Issues in Mental Health Nursing*, *28*, 943–975. doi:10.1080/01612840701522127.

Copeland, D., & Heilemann, M. (2008). Getting "to the point": The experience of mothers getting assistance for their adult children who are violent and mentally ill. *Nursing Research*, *57*, 136–143.

Cordner, G. (2006). Office of Community Oriented Policing Series, U.S. Department of Justice. People with mental illness. In Problems-Specific Guides Series, Retrieved from http://www.popcenter.org/problems/PDFs/MentalIllness.pdf.

Corker, E. (2001). Stigma caused by psychiatrists. *British Journal of Psychiatry*, *178*, 379.

www.manaraa.com

Corrigan, J. (2008, July 21). *How misperceptions drive social and political agendas*. Retrieved from http://www.reuters.com/article/pressRelease/idUS153579+21-Jul-2008+PRN20080721.

Corrigan, P. W. (2002). Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*, *73*, 217–228.

Corrigan, P. W. (2004). Target-specific stigma change: A strategy for impacting mental illness stigma. *Psychiatric Rehabilitation Journal, 28*, 113–121.

Corrigan, P. W., Larson, J. E., & Kuwabara. S. A. (2009). Self-stigma and the why try effect. *World Psychiatry*, *8*, 75–81.

Corrigan, P. W., & Lundin, R. (2001). *Don't call me nuts! Coping with the stigma of mental illness*. Tinley Park, IL: Recovery Press.

Corrigan, P., River, L. P., Lundin, R., Penn, D., Uphoff–Wasowski, K., Campion, J., & Kubiak, M. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin, 27*, 187–195.

Corrigan, P., Rowan, D., Green, A., Lundin, R., River, P., Uphoff–Wasowski, K., Kubiak, M. (2002). Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophrenia Bulletin*, *28*, 293–310.

Corrigan, P., & Watson, A. (2008). Understanding and influencing the stigma of mental illness. *Journal of Psychosocial Nursing*, *46*, 42–48.

Crawford, J. M. (1999). Co-parent adoptions by same-sex couples: From loophole to law. *Families in Society: The Journal of Contemporary Human Services, 80*, 271–278.

Crisanti, A. (2000). Experience with involuntary hospitalization: A qualitative study of mothers of adult children with schizophrenia. *Schizophrenia Research*, *45*, 79–81.

www.manaraa.com

Cummings, S. M. & Kropf, N.P. (2011). Aging with a severe mental illness: Challenges and treatments. *Journal of Gerontological Social Work. 54,* 175-188.

Dave, D., & Mukerjee, S. (2009). Mental health parity legislation, cost-sharing, and substance-abuse treatment admissions. *Health Economics*. Advance online publication. Retrieved from http://www.nber.org/papers/w14471.pdf.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice, 6,* 165–187.

Davis, D., & Silver, B. (2004). Civil liberties vs. security: Public opinion in the context of the terrorist attacks on America. *American Journal of Political Science, 48,* 28–46.

Deadliest campus shooting. (2007, April 16). *Richmond Times Dispatch*. Retrieved from http://www.richmondtimesdispatch.com.

Dentzer, S. (2009). Mental health care in America: Not yet good enough. *Health Affairs, 28,* 635–648.

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1–18). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Department of Mental Health, Mental Retardation, and Substance Abuse Services. (2011). *Rules and regulations for the licensing of providers of mental health, mental retardation and substance abuse services.* Chapter 105. Retrieved from http://www.dbhds.virginia.gov/documents/ol-12VAC35-105Dec2011.pdf.

www.manaraa.com

Department of Mental Health, Mental Retardation, and Substance Abuse Services. (2008). *A study of civil commitment hearings held in the Commonwealth of Virginia during May 2007. A Report to the Commission on Mental Health Law Reform.* Retrieved from http://www.dbhds.virginia.gov/OMH-MHReform/080603Criteria.pdf Department of Behavioral Health and Developmental Services. (2010). Differences in Civil Commitment Practice in Virginia. Retrieved from http://www.dbhds.virginia.gov/OMH-MHReform/2010-Diff-Civil-Commitment.ppt.

Depression Guideline Panel. (1993). *Clinical practice guideline number 5: Depression in primary care II* (AHCPR Publication No. 93-0551). Rockville, MD: U.S. Department of Health and Human Services.

Deutsch, A. (1936). *The mentally ill in America.* New York, NY: Columbia University Press.

DiFranks, N. (2008). Social Workers and the NASW Code of Ethics: Belief, Behavior, Disjuncture. *Social Work, 53.* 167-176.

Disability Advocates, Inc., v. Paterson, 653 F. Supp. 2d 184 (E.D. N.Y. 2009).

Dorothea Dix. (n.d.). *Women's intellectual contributions to the study of mind and society*. Retrieved from http://www.webster.edu/~woolflm/dorotheadix.html.

DuBois, J. (2008). *Ethics in mental health research: Principles, guidance, and cases*. New York, NY: Oxford University Press.

Dunham, A. (1985). APA's model law: Protecting the patient's ultimate interests. *Hospital and Community Psychiatry, 36*, 973–975.

Dwane, C. (2011). Environmentalism & social work: The ultimate social justice issue. *Social Work Today. 11,* 20.

www.manaraa.com

Eisenberg, L. (2005). Violence and the mentally ill: Victims, not perpetrators. *Archives of General Psychiatry, 62*, 825–826.

Elbogen, E. B., Mustillo, S., Van Dorn, R., Swanson, J., & Swartz, M. (2007). The impact of perceived need for treatment on risk of arrest and violence among people with severe mental illness. *Criminal Justice and Behavior*, *34*, 197–210.

Ellis, H. (2011). The Crisis Intervention Team—A Revolutionary Tool for Law Enforcement: The Psychiatric-Mental Health Nursing Perspective. *Journal of Psychosocial Nursing and Mental Health Services.* 49, 37-43. DOI: 10.3928/02793695-20111004-01.

Eltis, K. (2006). Predicting dignity on autonomy? The need for further inquiry into the ethics of tagging and tracking. *Elder Law Journal*, *13*, 387–391.

Engleman, N., Jobes, D., Berman, A., & Langbeing, L. (1998). Clinicians' decision making about involuntary commitment. *Psychiatric Services*, *49*, 941–945.

Enis, B. (1978). Judicial involvement in public practice of psychiatry. In W. E. Barton & C. J. Sanborn (Eds.), *Law and the mental health professions* (pp. 1–17). New York, NY: International Universities Press.

Eronen, M., Angermeyer, M. C., & Schulze, B. (1998). The psychiatric epidemiology of violent behavior. *Social Psychiatry and Psychiatric Epidemiology, 33* (Suppl. 1), S13–S23.

Farhood. L. F., Chaaya, M., & Saab, B. R. (2010). Detainment and health: The case of the Lebanese hostages of war. *International Journal of Mental Health Nursing, 19,* 83-91.

Ferris, C. (2008). The search for due process in civil commitment hearings: How procedural realities have altered substantive standards. *Vanderbilt Law Review*, *61*, 960–981.

Fieser, J., & Dowden, B. (2009). Social contract theory. *The Internet encyclopedia of philosophy*. Retrieved from http://www.iep.utm.edu/soc-cont/.

www.manaraa.com

Finkelman, A. (2000). Psychiatric patients and families: Moving from a catastrophic event to long-term coping. *Home Care Provider, 5*, 142–147. doi:10.1067/mhc.2000.109231.

Foley, S., Kelly, B., Clarke, M., McTuque, O., Gervin, M., Kamali, M., & Browne, S. (2005). Incidence and clinical correlates of aggression and violence at presentation in patients with first episode psychosis. *Schizophrenia Research, 72*, 161–168.

Foley, H., & Sharfstein, S. (1983). *Madness and government: Who cares for the mentally ill?* Washington, DC: American Psychiatric Press.

Foster, H. (1978). Informed consent of mental patients. In W. E. Barton & C. J. Sanborn (Eds.), *Law and the mental health professions* (pp. 71–96). New York, NY: International Universities Press.

Freeth, R. (2007). Working within the medical model. *Healthcare Counseling & Psychotherapy Journal*, *4*, 3–7.

Friedman, L., Hrouda, D., Noffsinger, S., Renick, P., & Buckley, P. (2003). Psychometric relationships of insight in patients with schizophrenia who commit violent acts. *Schizophrenia Research, 621*, 60–81.

Friend, C. (2006). Social contract theory. *The Stanford encyclopedia of philosophy*. Retrieved from http://www.iep.utm.edu/s/soc-cont.htm.

Garety, P. A., Fowler, D., & Kuipers, E. (2000). Cognitive-behavioral therapy for medication-resistant symptoms. *Schizophrenia Bulletin, 26,* 73–86.

Garfinkel P.E. & Goldbloom D.S.(2000). Mental health— getting beyond stigma and categories. *Bulletin of the World Health Organization, 78*: 503–505.

Garner, B. (1999). *Black's law dictionary*. St. Paul, MN: West.

www.manaraa.com

Gaskins, R., & Wasow, M. (1979). Vicious circles in civil commitment. *Social Work, 3*, 127–131.

Gaus, G. F. (2007). On justifying the liberties of the moderns. *Social Philosophy & Policy*, *25*, 84–119.

Gaus, G., & D'Agostino, F. (2008). Contemporary approaches to the social contract. *The Stanford encyclopedia of philosophy*. Retrieved from http://plato.stanford.edu/entries/contractarianism-contemporary/Geller, J. (2007). Invisible on judgment day. *Psychiatric Services*, *58*, 177–178.

Geller, J. (2008). Commentary: Is CIT today's lobotomy?. *Journal of American Academy of Psychiatry Law*, 32, 56-58. Retrieved from http://www.jaapl.org/content/36/1/56.long.

Giordano, S. (2000). For the protection of others. *Health Care Analysis*, 8, 309–319.

Glazer, B. (1992). *Basics of grounded theory analysis: Emergence vs. forcing*. Mill Valley, CA: Sociology Press.

Glazer, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: Aldine.

Glied, S., & Frank, R. (2009). Better but not best: Recent trends in the well-being of the mentally ill. *Health Affairs*, *28*, 637–648.

Gollaher, D. (1995). *Voice for the mad: The life of Dorothea Dix*. New York, NY: Free Press.

Gostin, L. (2001). Beyond moral claims: A human rights approach in mental health. *Cambridge Quarterly of Healthcare Ethics*, *10*, 264–274.

Gove, W. (1980). Labeling and mental illness: A critique. In W. Gove (Ed.), *Labeling deviant behavior* (pp. 345-354). Beverly Hills, CA: Sage.

www.manaraa.com

Grand jury rules shooting death of mentally ill Chesterfield man was justified. (2009, July 17). *Richmond Times Dispatch*. Retrieved from http://www.richmondtimesdispatch.com

Gredler, M. E. (1997). *Learning and instruction: Theory into practice* (3rd ed). Upper Saddle River, NJ: Prentice-Hall.

Green, T. (1997). Police as frontline mental health workers. *International Journal of Law and Psychiatry, 20*, 469–486.

Grohol, J. (2005). *Severely mentally ill more likely victims than perpetrators of violence*. Retrieved from http://psychcentral.com/blog/archives/2005/08/01/severely-mentally-ill-more-likely-victims-than-perpetrators-of-violence/.

Guba, E. G. (1985). The context of emergent paradigm research. In Y. S. Lincoln (Ed.), *Organization theory and inquiry: The paradigm revolution* (pp. 79–104). Beverly Hills, CA: Sage.

Guba, E. G. (Ed.). (1992). *The alternative paradigm*. London, UK: Sage.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation.* Newbury Park, CA: Sage.

Guba, E.G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research: Theories and issues* (pp. 195–220). Thousand Oaks, CA: Sage.

Gutting, G. (2008). Michel Foucault. In E. N. Zalta (Ed.), *The Stanford encyclopedia of philosophy*. Retrieved from http://plato.stanford.edu/archives/win2008/entries/foucault/

Hallam, L. (2007). How involuntary commitment impacts on the burden of care of the family. *International Journal of Mental Health Nursing*, *16*, 257–256.

Hampton, J. (1986). *Hobbes and the social contract tradition*. Cambridge, UK: Cambridge University Press.

www.manaraa.com

Hanson, K. W. (1998). Public opinion and the mental health parity debate: Lessons from the survey literature. *Psychiatric Services, 49,* 1059–1066.

Hamric, A. B., Spross, J. A., & Hanson, C. M. (2000). *Advanced nursing practice an integrative approach* (2nd ed.). Toronto: Saunders.

Hartford, K., Carey, R., & Mendonca, J. (2006). Pre-arrest diversion of people with mental illness: Literature review and international survey. *Behavioral Sciences & The Law, 24,* 845–856.

Harvard Mental Health Letter. (2008). *Involuntary outpatient commitment*. Retrieved from http://www.health.harvard.edu.

Heginbotham, C. (1998). UK mental health policy can alter the stigma of mental illness. *Lancet, 352,* 1052–1053.

Henrico man gets nearly 15 years in mother's stabbing death. (2009, October 7). *Richmond Times Dispatch*. Retrieved from http://www.richmondtimesdispatch.com.

Henwood, B. (2008). Involuntary inpatient commitment in the context of mental health recovery. *American Journal of Psychiatric Rehabilitation, 11,* 253–266.

Herbert, P. (2004). Psychotherapy as law enforcement. *Journal of the American Academy of Psychiatry and the Law, 22,* 91–95.Herlitz, G., (1994). The meaning of the term 'Prima Facie.' *Louisiana Law Review.* 55. https://litigation-essentials.lexisnexis.com/webcd/app?action=DocumentDisplay&crawlid=1&doctype=cite&docid=55+La.+L.+Rev.+391&srctype=smi&srcid=3B15&key=22778fec8843db643a87755f3d8bc566Hiday, V. (1983). Are lawyers enemies of psychiatrists? A survey of civil commitment counsel and judges. *American Journal of Psychiatry, 140,* 323–326.

www.manaraa.com

Hiday, V. (2006). Civil commitment: A review of empirical research. *Behavioral Sciences and the Law*, 6, 15–43.

Hoge, S., Lidz, C., Eisenberg, M., Monahan, J., Bennett, N., Gardner, W., & Roth, L. (1998). Family, clinician, and patient perceptions of coercion in mental hospital admission. *International Journal of Law and Psychiatry*, *21*, 131–146.

Hoenig, J., & Hamilton, M.W. (1966). The schizophrenic patient in the community and his effect on the household. *International Journal of Social Psychiatry*, 12:165-176.

Hudson, C. G. (2012). Disparities in the geography of mental health: implications for social work. *Social Work*. *57*. 107-119.

Hughes, R., Hayward, M., & Finlay, W. (2009). Patients' perceptions of the impact of involuntary inpatient care on self, relationships, and recovery. *Journal of Mental Health*, *18*, 152–160.

Hymes, D. (2008a, July 3). The new easier civil commitment laws: At least they fixed the problems in Cho's case, right? Wrong. *Charlottesville Prejudice and Civil Rights Watch*. Retrieved from http://hymes.wordpress.com/.

Hymes, D. (2008b, June 29). The new mental health laws are worse than you thought: A radical interpretation of the laws by Bonnie, Cohen, and Monahan is being taught to all Special Justices and CSB staff. *Charlottesville Prejudice and Civil Rights Watch*. Retrieved from http://hymes.wordpress.com/2008/06/29/hypothetical-example-of-involuntary-commitment-under-the-new-laws-interpretation-by-bruce-cohen-md-richard-bonnie-and-john-monahan-and-used-in-training-all-virginia-special-justices/.

www.manaraa.com

Hymes, D. (2008c, August 24). Outpatient commitment is about money, not public safety or "caring coercion." *Charlottesville Prejudice and Civil Rights Watch*. Retrieved from http://hymes.wordpress.com/

Ikkos, G., Boardman, J., & Zigmond, T. (2006). Talking liberties: John Rawls's theory of justice and psychiatric practice. *Advances in Psychiatric Treatment, 12*, 202–213.

Insel, T. R., & Wang, P. S. (2010). Rethinking mental illness. *Journal of the American Medical Association, 303*, 1970–1971.

Institute of Medicine. (2012). Substance use disorders in the U.S. Armed Forces. Institute of Medicine of the National Academies. Retrieved on http://www.iom.edu/~/media/Files/Report%20Files/2012/Military-SUD/SUD_rb.pdf.

Jackson v. Indiana, 406 U.S. 715 (1972).

Jacobson, N. (2009). A taxonomy of dignity: A grounded theory study. *BMC International Health and Human Rip-ghts, 9*(3), 1–9. doi:10.1186/1572-698x-9-3.

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services, 52*, 482–485. Retrieved from http://psychservices.psychiatryonline.org.

Jaffe, D. (2011, May 19). Still mentally ill and still dangerous: Court-ordered treatment for the disturbed needs to be fixed. *TheNYDaily News.com*. Retrieved from http://articles.nydailynews.com/2011-05-19/news/29576203_1_mental-illness-kendra-s-law-court-ordered-treatment.

Jenson, J. (2007). Aggression and violence in the United States: Reflections on the Virginia Tech shootings. *Social Work Research, 31*, 131–137.

www.manaraa.com

Johnson, D. (2000). On giving up on the mental health system. *New Directions for Mental Health Services*, *88*, 27–38.

Joint Legislative Audit and Review Commission of the Virginia General Assembly. (1994). Interim report: Review of the involuntary civil commitment, House Document 77, Commonwealth of Virginia.

Jonassen, D. H. (1994). Thinking technology: Toward a constructivist design model. *Educational Technology Research and Development*, *34*(4), 34–37.

Jungbaue, J., Wittmund, B., Dietrich, S., & Angermeyer, M., (2004). The disregarded caregivers: Subjective burden in spouses of schizophrenia patients. *Schizophrenia Bulletin*, Vol. 30, No. 3, 2004.

Kallert, T. (2008). Coercion in psychiatry. *Current Opinion in Psychiatry*, *21*, 485–489.

Kallert, T., Blockner, M., & Schutzwohl, M. (2008). Involuntary vs. voluntary hospital admission. A systematic literature review on outcome diversity. *Psychiatry Clinical Neuroscience*, *4*, 195–209.

Kasper, J., Hoge, S., Feucht–Haviar, T., Cortina, J., & Cohen, B. (1997). Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. *American Journal of Psychiatry*, *154*, 483–489.

Katsakou, C., & Priebe, S. (2007). Patients' experience of involuntary hospital admission and treatment: A review of qualitative studies. *Epidemiology Psychiatric Sociology*, *16*, 173–178.

Kennedy, P. (2002, January 28). *Mental health policy in the 21st century*. Austin: Texas Medical Association, University of Texas Southwestern, Department of Psychiatry.

www.manaraa.com

Kenyon, G. L., Chong, K., Enkoff–Sage, M., Hill, C., Mays, C., & Rochelle, L. (2003). Public adoption by gay and lesbian parents in North Carolina: Policy and practice. *Family in Society, 84*, 571–575.

Kim, B. (2001). Social constructivism. In M. Orey (Ed.), *Emerging perspectives on learning, teaching, and technology*. Retrieved from http://projects.coe.uga.edu/epltt/.

Kitamura, T., & Takahashi, N. (2007). Ethical and conceptual aspects of capacity assessments in psychiatry. *Current Opinion in Psychiatry*, *20*, 578–581.

Koivisto, K., Janhonen, S., Latvala, E., & Vusunen, L. (2001). Applying ethical guidelines in nursing research on people with mental illness. *Nursing Ethics*, *8*, 328–339. Retrieved from http://www.ualberta.ca/~iiqm/backissues/2_3final/pdf/laverty.pdf.

Kress, K. (2006). Rotting with their rights on: Why criteria for ending commitment or restraint of liberty need not be the same as criteria for initiating commitment or restraint of liberty, and how the restraint may sometimes justifiably continue after its prerequisites are no longer satisfied. *Behavioral Sciences and the Law*, *24*, 572–598. doi:10.1002/bsl.709

La Fond, J. (1994). Law and the delivery of involuntary mental health services. *American Journal of Orthopsychiatry*, *64*, 209–222.

La Fond, J., & Durham, M. (1992). *Back to the asylum: The future of mental health law in the United States.* New York, NY: Oxford University Press.

Laing, R. D. (1971). *The politics of the family and other essays*. London, UK: Tavistock.

Lake v. Cameron, 118 U.S. App. D.C. 25, 331 F.2d 771 (1964).

Lamb, H., Shaner, R., Elliott, D., DeCuir, W., & Foltz, J. (1995). Outcome for psychiatric emergency patients seen by an outreach police-mental health team. *Psychiatric Services*, *46*, 1267–1271.

www.manaraa.com

Lamb, H., & Weinberger, L. (1998). The persons with severe mental illness in jails and prisons: A review. *Psychiatric Services*, *49*, 483–492. Retrieved from http://psychservices.psychiatryonline.org.

Lamb, H., Weinberger, L., & DeCuir, W. (2002). The police and mental health. *Psychiatric Services*, *53*, 1266–1271. Retrieved from http://psychservices.psychiatryonline.org.

Large, M., Ryan, C., Nielssen, O., & Hayes, R. (2008). The danger of dangerousness: Why we must remove the dangerousness criterion from our mental health acts. *Journal of Medical Ethics*, *34*, 877–881.

Larson, J., & Corrigan, P. (2008). The stigma of families with mental illness. *Academic Psychiatry*, *32*, 87–91.

Laugharne, J., Lille, A., & Janca, A. (2010). Role of psychological trauma in the cause and treatment of anxiety and depressive disorders. *Current Opinion in Psychiatry*, *23*, 25–29.

Lawrence v. Texas, 539 U.S. 558 (2003).

Leavitt, M., Spellings, M., & Gonzales, A. (2007). *Report to the president on issues raised by the Virginia Tech tragedy*. Retrieved from http://www.hhs.gov/vtreport.html.

Lebensohn, Z. (1978). Defensive psychiatry or how to treat the mentally ill without being a lawyer. In W. E. Barton & C. J. Sanborn (Eds.), *Law and the mental health professions* (pp. 19–46). New York, NY: International Universities Press.

Levin, A. (2005). When mental illness makes news, facts often missing in action. *Psychiatric News*. Retrieved from http://on.psychiatryonline.org/content/40/12/18.1.full?sid=6955eba7-a0b9-aba2b9d75e44.

www.manaraa.com

Lilja, L., & Helzein, O. (2008). Former patients' experience of psychiatric care: A qualitative investigation. *International Journal of Mental Health Nursing, 17*, 279–286.

Linburn, E. (1998). Donaldson revisited: Is dangerousness a constitutional requirement for civil commitment? *Journal of the American Academy of Psychiatry and Law*, *26*, 343–351.

Lincoln, A. (1864). Address at a sanitary fair. Retrieved from http://teachingamericanhistory.org/library/index.asp?document=1067.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, NJ: Sage.

Link, B. (1982). Mental patients' status, work, and income: An examination of the effects of a psychiatric label. *American Sociological Review*, *47*, 202–215.

Link, B. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, *52*, 96–112.

Link, B. (2003). *Stigma research and current perspectives*. Keynote address presented at Stigma and Mental Illness: A Working Forum, Piscataway, NJ.

Link, B., & Phelan, J. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*, 363–385. doi:10.1146/annurev.soc.27.1.363.

Link, B., Phelan, J., Bresnahan, M., Stueve, A., & Pescosolido, B. (1999). Public conceptions of mental illness: The labels, causes, dangerousness, and social distance. *American Journal of Public Health*. *89*, 1328–1334.

Link, B., Struening, E., Cullen, F., Shrout. P., & Dohrenwent, B. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, *54*, 400–423.

www.manaraa.com

Link, B., Struening, E., Rahav, M., Phelan, J., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse. *Journal of Health and Social Behavior, 38,* 177–190.

Lightfoot, J. (2011, January 27). Don't overlook dangerous stereotypes of the mentally ill. *Crosscut Public Media.* Retrieved from http://realchangenews.org/index.php/site/past-issue-index/5216.

Lloyd, S., & Sreedhar, S. (2008). *Hobbes's moral and political philosophy*. Retrieved from http://plato.stanford.edu/entries/hobbes-moral.

Lopez, J. (2002). The power of stigma. *World Psychiatry, 1*(1), 23–24. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489824/.

Loue, S. (2002). The involuntary civil commitment of mentally ill persons in the United States and Romania. *Journal of Legal Medicine, 23,* 211–250.

Luchins, D., Cooper, A., Hanrahan, P., & Heyrman, M. (2006). Lawyers' attitudes toward involuntary treatment. *Journal of American Academy of Psychiatry and Law, 34,* 492–500.

Manderscheid, R. W., & Henderson, M. J. (Eds.). (2001). *Mental health, United States, 2000* (DHHS Pub No. SMA 01-3537). Washington, DC: U.S. Government Printing Office.

Man's death in Chesterfield standoff ruled justified. (2009, November 24). *Richmond Times Dispatch*. Retrieved from http://www.richmondtimesdispatch.com.

Martinson, F. (1970). *Family in society*. New York, NY: Dodd, Mead, & Co.

Mateu, M., & Cuadra, A. (2007). The stigma that mental health bears. A challenge for the 21st century. *Revista de enfermagem, 30*(11), 16–18.

www.manaraa.com

Matiti, M., & Cotrel–Gibbons, E. (2007). Promoting patient dignity in healthcare settings. *Nursing Standards*, *21*(45), 46–52.

Matthews, E. (2000). Autonomy and the psychiatric patient. *Journal of Applied Philosophy, 16*, 59–70.

Merriam-Webster Dictionary. (2012). Infrastructure. Retrieved from http://www.merriam-webster.com/dictionary/infrastructure.

McConnell, Terrance, "Moral Dilemmas", *The Stanford Encyclopedia of Philosophy (Summer 2010 Edition)*, Edward N. Zalta (ed.), Retrieved from <http://plato.stanford.edu/archives/sum2010/entries/moral-dilemmas/>.

McCubbin, M., Dallaire, B., Cohen, D., & Morin, P. (1999). Should institutions that commit patients also be gatekeepers to information about civil commitment? *Radical Psychology*, *1*(2), 1–18. Retrieved from http://radicalpsychology.org/vol1-2/mccubbin.html.

McDonald, A., & Paitich, D. (1981). A study of homicide: The validity of predictive factors. *Canadian Journal of Medicine*, *26*, 549–554.

McFarland, B., Faulkner, L., Bloom, J., Hallaux, R., & Bray, J. (1990a). Experiences with involuntary hospitalization: A qualitative study of mothers of adult children with schizophrenia. *Schizophrenia Research*, *45*, 79–81.

McFarland, B., Faulkner, L., Bloom, J., Hallaux, R., & Bray, J. (1990b). Family members' opinions about civil commitment. *Hospital and Community Psychiatry*, *41*, 537–540.

McGravey, E. (2007). *Civil commitment practices in Virginia, perceptions, attitudes, and recommendations. A report for the Commission of Mental Health and Law Reform, Commonwealth of Virginia*. http://www.courts.state.va.us/cmh/civil_commitment_practices_focus_groups.pdf.

www.manaraa.com

McLaughlin, A. (2009). Clinical social workers: advocates for social justice. *Advances in Social Work* . 10, 51-68

Menchetti, A., Tonti, M., Scarlatti, C., Lundgren, E., Esposito, W., & Berardi, D. (2008). Predictors of violent behavior among acute psychiatric patients: Clinical study. *Psychiatry of Clinical Neuroscience, 62*, 247–255.

Mental illness. (2010). *Richmond Times Dispatch*. Retrieved from http://search.timesdispatch.com/Search.jsp.

Mental Health Association of New River Valley. (2012). New River Valley Crisis Intervention Team Program, Retrieved from http://www.mhanrv.org/crisis_intervention.html.

Mill, J. (1959). On liberty. In *The collected works of John Stuart Mill, Volume XVIII—Essays on politics and society, part I.* Retrieved from http://oll.libertyfund.org/index.php?option=com_staticxt&staticfile=show.php%3Ftitle=233&chapter=16550&layout=html&Itemid=27.

Mill, J. (1993). *Utilitarianism, on liberty, considerations on representative government*. London, UK: Everyman.

Mirabi, M., Weinman, M., Magnetti, S., & Keppler, K. (1985). Professional attitudes toward the chronically mentally ill. *Hospital and Community Psychiatry, 36*, 404–405.

Mirabito, D. (2011). Educating a new generation of social workers: Challenges and skills needed for contemporary agency-based practice. *Clinical Social Work Journal*. 40, 245-254.

Monahan, J., Hoge, S., Lida, C., Roth, L., Bennett, N., Gardner, W., & Mulvery, E. (1995). Coercion and commitment: Understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry, 18*, 249–263.

www.manaraa.com

Morabito, M. (2007). Horizons of context: Understanding the police decision to arrest people with mental illness. *Psychiatric Services, 58,* 1582–1587. Retrieved from ps.pwychiatryonline.org

Morden, N., Mistler, L., Weeks, W., & Bartels, S. (2009). Health care for patients with serious mental illness: Family medicine's role. *Journal of the American Board of Family Medicine, 22,* 187–195. Retrieved from doi:10.3122/jabfn.2009.02.080059.

Morris, S. (1982). A preference for liberty: The case against involuntary commitment of the mentally disordered. *California Law Review, 70,* 54–106.

Morrissey, J., Fagan, J., & Cocozza, J. (2009). New models of collaboration between criminal justice and mental health systems. *American Journal of Psychiatry, 166,* 1211–1214. Retrieved from http://psychservices.psychiatryonline.org.

Morse, S. (1982). A preference for liberty: The case against involuntary commitment of the mentally disordered. *California Law Review, 70,* 54–106.

Murray, C. J. L., & Lopez, A. D. (Eds.). (1996). *The global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge, MA: Harvard School of Public Health.

Musters, C. (2010). Managing patients without their consent: A guide to recent legislation. *British Journal of Hospital Medicine, 77,* 87–90.

National Alliance on Mental Illness. (2012). Hospital Safety Officers: The Newest Innovation in CIT. Retrieved from http://www.nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=135744.

www.manaraa.com

National Alliance on Mental Illness. (2010). *Mental illness*. Retrieved from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm.

National Alliance on Mental Illness. (2010b). *Mental illness*. Retrieved from http://www.nami.org/template.cfm?section=about_mental_illness.

National Alliance on Mental Illness. (2012). *About Public Policy*. Retrieved from http://www.nami.org/template.cfm?section=about_public_policy.

National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers.* Washington, DC: NASW Press.

National Association of Social Workers. (2000a). *Examining mental health service needs in pediatric primary care settings*. Retrieved from http://www.socialworkers.org/research/naswResearch/0204mHealth/abstractPed.asp.

National Association of Social Workers. (2000b). *The mental health recovery model*. Retrieved from http://www.socialworkers.org/practice/behavioral_health/0206snapshot.asp.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America: Final report* (DHHS Pub. No. SMA-03-3832). Rockville, MD: Department of Health and Human Services.

O'Connor v. Donaldson, 422 US 563 (1975).

O'Connor, D., & O'Neill, B. (2009). Toward social justice: Teaching qualitative research. *Journal of Teaching in Social Work, 24*(3/4). doi:10.1300/J067v24n02_02

Office of Social Work Specialty Practice. (2006, February). *NASW practice snapshot: The mental health recovery model*. Retrieved from http://www.naswdc.org/practice/behavioral_health/0206snapshot.aspOhio Office of

www.manaraa.com

Criminal Justice Services. (2005). *RESEARCH BRIEFING 1:The Effect of Crisis Intervention Team Training on Police Disposition of Mental Disturbance Calls.* Retrieved from http://www.publicsafety.ohio.gov/links/ocjs_researchbriefing1.pdf.

Olofsson, B., & Jacobsson, L. (2001). A plea for respect: Involuntarily hospitalized psychiatric patients' narrative about being subjected to coercion. *Journal of Psychiatric and Mental Health Nursing*, *8*, 356–366.

Pantilat, S. (2008). Autonomy vs. Beneficence. Retrieved from http://missinglink.ucsf.edu/lm/ethics/Content%20Pages/fast_fact_auton_bene.htm

Parrish, B. (2009). *VOCAL's policy statement of mental health law and reform in Virginia*. Retrieved from http://www.vocalnetwork.org/VOCAL%20Policy%20Statement.htm.

Parry, M. (2006). Dorothea Dix (1802-1887). *American Journal of Public Health*. *96*(4), 624-625 retrieved from doi: 10.2105/AJPH.2005.079152.

Patch, P. C., & Arrigo, B. A.(1999). Police officer attitudes and use of discretion in situations involving the mentally ill. The need to narrow the focus. *International Journal of Law and Psychiatry*, *22*, 23–35.

Peris, T., Teachman, G., & Nosek, B. (2008). Implicit and explicit stigma of mental illness: Links to clinical care. *Journal of Nervous and Mental Disease*, *196*, 752–760.

Perlin, M. L. (2002). Things have changed: Looking at non-institutional mental disability law through the sanism filter. *NYLS Law Review.* Retrieved from http://ssrn.com/abstract=345140 or doi:10.2139/ssrn.345140.

Perlin, M. L. (2003). Therapeutic jurisprudence and outpatient commitment law: Kendra's Law as case study. *Psychology, Public Policy, and Law*, *9*, 183–208.

www.manaraa.com

Perlin, M., & Douard, J. (2009). Equality, I spoke that word/as if a wedding vow: Mental disability law and how we treat marginalized persons. *New York Law School Law Review, 53*(9). Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1338298#.

Perlin, M., Gould, K., & Dorfman, D. (1995). Therapeutic jurisprudences and the civil rights of institutionalized mentally disabled persons: Hopeless oxymoron or path to redemption? *Psychology, Public Policy, and Law*, *1*, 80–119.

Perring, Christian, "Mental Illness", *The Stanford Encyclopedia of Philosophy (Spring 2010 Edition)*, Edward N. Zalta (ed.), Retrieved from <http://plato.stanford.edu/archives/spr2010/entries/mental-illness/.

Pescosolido, B., Martin, J., Link, B., Kikuzawa, S., Burgos, G., & Swindle, R. (2000). *Americans' views of mental illness and health at century's end: Continuity and change. Public report on the MacArthur Mental Health Module, 1996 General Social Survey*. Bloomington, IN: Indiana Consortium for Mental Health Services Research.

Pescosolido, B., Monahon, J., Link, B., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health, 89*, 1339–1345.

Peterson, K. J. (2012). Shared decision making in health care settings: A role for social work. *Social Work in Health Care. 51*. 894-908.

Phelan, J., Bromet, E., & Link, B. (1998). Psychiatric illness and family stigma. *Schizophrenia Bulletin*, *24*, 115–126.

www.manaraa.com

Phelan, J., & Link, B. (1998). The growing belief that people with mental illnesses are violent: The role of the dangerousness criterion for civil commitment. *Sociology, Psychiatry, & Psychiatric Epidemiology, 33,* S7–S12.

Phelan, J., Link, B., Stueve, A., & Pescosolido, B. (1997, August). *Public conceptions of mental illness in 1950 in 1996: Has sophistication increased? Has stigma declined?* Paper presented at the meeting of the American Sociological Association, Toronto, Ontario.

Phelan, J., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health & Social Behavior, 44,* 188–207.

Pickard, A., & Dixon, P. (2004). The applicability of constructivist user studies: How can constructivist inquiry inform service providers and systems designers? *Information Research, 9*(3). Retrieved from http://informationr.net/ir/9-3/paper175.html.

Poletick, F. (2002). How psychiatrists and judges assess the dangerousness of persons with mental illness: An "expertise bias." *Behavioral Sciences and the Law, 20,* 19–29.

Pouncey, C., & Lukens, C. (2010). Madness versus badness: The ethical tension between the recovery movement and forensic psychiatry. *Theoretical Medicine and Bioethics, 31,* 93–105. doi:10.1007/s11017-010-9138-9.

Prinsen, E., & vonDelden, J. (2009). Can we justify eliminating coercive measures in psychiatry? *Journal of Medical Ethics, 35,* 69–73.

Radden, J. (2009). Classifying dysthymia. *APA Newsletter on Philosophy and Medicine, 8*(2), 8–12.

Ralph, R., & Corrigan, P. (Eds.). (2005). *Recovery in mental health: Broadening our understanding of wellness.* Washington, DC: American Psychological Association.

www.manaraa.com

RAND Institute for Civil Justice and Rand Health. (2000). *Does involuntary outpatient treatment work?* (Research Brief). Retrieved from http://www.rand.org/pubs/research_briefs/RB4537/index1.html.

Rawls, J. (1999). *A theory of justice*. Cambridge, MA: Belknap Press of Harvard University Press.

Reid, W. (2003). Back to basics: Law and mental health. *Journal of Psychiatric Practice, 9*, 240–244.

Rennie v. Klein, 462 F. Supp. 1131 (D.N.J. 1978).

Reuland, M., Schwarzfeld, M., & Draper, L. (2009). Law enforcement responses to people with mental illnesses: A guide to research-informed policy and practice. New York, NY: Council of State Governments Justice Center.

Richmond killer is found insane. (2008, July 17). *Richmond Times Dispatch*. Retrieved from http://www.richmondtimesdispatch.com.

Ridgely, M., Petrila, J., & Borum, R. (2000). *Study on involuntary treatment for people with mental illness*. Santa Monica, CA: RAND Institute for Civil Justice.

Robertson, M. (2007a). Part I: Psychiatrists and social justice—The concept of justice. *Journal of Ethics in Mental Health, 2*(1), 3-6.

Robertson, M. (2007b). Part II: Psychiatrists and social justice—When the social contract fails. *Journal of Ethics in Mental Health, 2*(1), 6-10.

Rodgers, J. (2010). Competencies in global social work practice: A kaleidoscope model. *Journal of Global Social Work Practice*. 3.

Rodwell, M. K. (1998). *Social work constructivist research*. New York, NY: Garland.

www.manaraa.com

Roth, L. (1979). A commitment law for patients, doctors, and lawyers. *American Journal of Psychiatry, 136*, 1121–1127.

Rothman, D. (2001). The origins and consequences of patient autonomy: A 25-year retrospective. *Health Care Analysis, 9*, 255–264.

Sadler, J. Z. (2005). *Values and psychiatric diagnosis*. Oxford, UK: Oxford University Press.

Sadoff, R. (1978). Implications for involuntary hospitalization: Dangerousness or mental illness. In W. E. Barton & C. J. Sanborn (Eds.), *Law and the mental health professions* (pp. 1–17). New York, NY: International Universities Press.

Salasky, P. (2011). Virginia's lack of beds results in "streeting" of mentally ill. retrieved from http://articles.dailypress.com/2011-10-18/health/dp-nws-streeting-report-1019-20111018_1_streeting-beds-detention.

Salzer, M., Blank, M., Rothbard, A., & Hadley, T. (2002). Status of mental health services at the millennium. In Substance Abuse and Mental Health Services Administration's National Mental Health Information Center, *Adult mental health services in the 21st century* (chap. 11). Retrieved from http://mentalhealth.samhsa.gov/publications/allpubs/sma01-3537/chapter11.asp.

Sarkar, S. (2006). *The welfare state: Justice or theft? Advances in psychiatric treatment*. Retrieved from http://apt.rcpsych.org/cgi/content/full/12/3/211.12.

Sartorius, N. (2004). Diminishing the stigma of schizophrenia. *Advances in Schizophrenia and Clinical Psychiatry, 1*, 50–54.

Sartorius, N., Lett, J., Lopez-Ibor, J., Maj, M., & Okasha, A. (2005). *Families and mental disorders: From burden to empowerment.* Chichester, UK: Wiley.

www.manaraa.com

Sartorius, N., & Schulze, H. (2005). *Reducing the stigma of mental illness. A report from a Global Programme of the World Psychiatric Association*. Cambridge, UK: Cambridge University Press.

Satcher, D. (1999). *Mental health: A report from the Surgeon General*. Washington, DC: Department of Health and Human Services.

Schmerber v. California, 384 U.S. 757 (1966).

Schopp, R., & Quattrocchi, M. (1995). Predicting the present: Expert testimony and civil commitment. *Behavioral Sciences and the Law*, *13*, 159–181.

Schulberg, H., & Killilea, M. (1982). *The modern practice of community mental health.* San Francisco, CA: Jossey-Bass.

Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, *19*, 137–155.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives, and mental health professionals. *Social Science & Medicine*, *56*, 299–312.

Schwarz, S., Froelich, L., & Burn, A. (2012) Pharmacological treatment of dementia. *Current Opinion in Psychiatry.* 25, 542-550. Retrieved from doi: 10.1097/YCO.0b013e328358e4f2.

Sharfstein, S. (2000). Whatever happened to community mental health? *Psychiatric Services, 51*, 616–620.

Sharfstein, S., & Dickerson, F. (2009). Hospital psychiatry for the twenty-first century. *Health Affairs*, *18*, 685–688.

www.manaraa.com

Silva, C. (2010, June 7). Medicare physician pay cut reversal in Senate's hands. *American Medical News.* Retrieved from http://www.ama-assn.org/amednews/2010/06/07/gvl10607.htm

Silvers, A., & Francis, L. (2005). Justice through trust: Disability and the "outlier problem" in social contract theory. *Ethics, 116,* 40–76.

Sluss, M. (2008). *Governor signs Virginia Tech-inspired mental health reform bills*. Retrieved from http://www.roanoketimes.com.

Smith, D. G. (1991). Hermeneutic inquiry: The hermeneutic imagination and the pedagogic text. In E. Short (Ed.), *Forms of curriculum inquiry* (pp. 187–209). Albany: University of New York Press.

Smith, L. (1989). Medication refusal and the rehospitalized mentally ill inmate. *Hospital and Community Psychiatry, 40,* 491–496.

Snow, N., & Austin, W. (2009). Community treatment orders: The ethical balancing act in community mental health. *Journal of Psychiatric and Mental Health Nursing, 16,* 177–186.

Sørgaard, K. (2007). Satisfaction and coercion among voluntary, persuaded/ pressured and committed patients in acute psychiatric treatment. *Scandinavian Journal of Caring Sciences, 21,* 214–219.

Stanage, S. M. (1987). *Adult education and phenomenological research: New directions for theory, practice, and research*. Malabar, FL: Robert E. Krieger.

Stanton, L., & Kohn, R. (2012). *Depression and the aging brain.* Medicine and Health Rhode Island. *95* 210-211.

Stavis, P. (1995, July 21). *Involuntary commitment: Past, present, and future.* Retrieved from http://www.cqcapd.state.ny.us/counsels_corner/cc64.htm2006.

www.manaraa.com

Steadman, J., Mulveye, P., Monahan, J., Robbins, P., Appelbaum, P., Grisso, T., Silver, E. (1998).Violence by people discharged from acute psychiatric in-patient facilities and by others in the same neighborhoods. *Archives of General Psychiatry*, *55*, 393–401.

Stein, L., & Diamond, R. (1985). The chronic mentally ill and the criminal justice system: When to call the police. *Hospital and Community Psychiatry*, *36*, 271–274.

Stone, D. (1998). *Policy paradox: The art of political decision making*. New York, NY: W. W. Norton.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

Struening, E., Perlick, D., Link, B., Hellman, F., Herman, D., & Sirey, J. (2001). Stigma as a barrier to recovery: The extent to which caregivers believe most people devalue consumers and their families. *Psychiatric Services*, *52*, 1633–1638. Retrieved from http://psychservices.psychiatryonline.org/cgi/content/abstract/52/12/1633.

Substance Abuse and Mental Health Services Administration. (2002). *National Mental Health Information Center President's New Freedom Commission on Mental Health*. Retrieved from www.mentalhealthommission.gov/report/download/finalreports.pdf.

Substance Abuse and Mental Health Services Administration. (2012) Trauma informed care. (n.d.). Retrieved from http://mentalhealth.samhsa.gov/nctic/trauma.asp#interventions/.

Sudak, H., Maxim, M., & Carpenter, M. (2008). Suicide and stigma: A review of the literature and personal reflections. *Academic Psychiatry*, *32*, 136–142.

Sussman, L. K., Robins, L. N., & Earls, F. (1987). Treatment-seeking for depression by Black and White Americans. *Social Science and Medicine*, *24*, 187–196.

Suzuki v. Quisenberry, 411 F. Supp 1113, 1118 (D. Haw. 1976).

www.manaraa.com

Swanson, J., Swartz, M., Elbogen, E., Wagner, H., & Burns, B. (2003). Effects of involuntary outpatient commitment on subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*, *21*, 473–491.

Swanson, J., Swartz, M., Essock, S., Osher, F., Wagner, H., Goodman, L. & Meador, K. (2002). The social–environmental context of violent behavior in persons treated for severe mental illness. *American Journal of Public Health*, *92*, 1523–1531.

Swartz, M., Burns, B., George, L, Swanson, J., Hiday, V., Borum, R., & Wagner, H. (1997). The ethical challenges of a randomized controlled trial of involuntary outpatient commitment. *Ethical Challenges*, *24*, 35–43.

Swartz, M. S., Swanson, J. W., Hiday, V., Borum, R., Wagner, H., & Burns, B. (1998). Violence and severe mental illness: The effects of substance abuse and non-adherence to medication. *American Journal of Psychiatry*, *155*, 226–231.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct*. New York, NY: Harper and Row.

Szasz, T. S. (2006). Psychiatry: A branch of the law. *The Freeman*, *56*, 18–20.

Tally, M. (2009). Self-labeling and its effects among adolescents diagnosed with mental disorders. *Social Science & Medicine*, *68*, 570–578.

Tanay, E. (2007). Virginia Tech mass murder: A forensic psychiatrist's perspective. *Journal of the American Academy of Psychiatry and Law*, *35*, 152–153.

Tarrier, N., Khan, S., Cater, J., & Picken, A. (2007). The subjective consequences of suffering a first episode psychosis: Trauma and suicide behavior. *Social Psychiatry*, *42*, 29–35.

www.manaraa.com

Taylor, M. (2006). Is self-determination still important? What experienced mental health social workers are saying. *Journal of Social Work Values and Ethics,* 3(1). Retrieved from http://www.socialworker.com/jswve/content/view/29/44/.

Taylor, S., & Dear, M. (1980). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin, 7*, 225–240.

Teplin, L., McClelland, G., Abram, K., & Weiner, D. (2005). Crime victimization in adults with severe mental illness. *Archives of General Psychiatry, 62*, 911–921.

Thesen, J. (2001). Being a psychiatric patient in the community-reclassified as the stigmatized "other." *Scandinavian Journal of Public Health, 29*, 248–255.

Tholen, A. (2009). Assessment and management of the risk for violence. An overview of the literature. *Tijdschr Psychiatrie, 51*, 173–182.

Thompson, E., & Doll, W. (1982). The burden of families coping with the mentally ill: An invisible crisis. *Family Relations, 31*, 379–388.

Thompson, J., & Ager, J. (2006). An experimental analysis of the civil commitment recommendations of psychologists and psychiatrists. *Behavioral Sciences & The Law*, *6*, 119–129.

Torrey, E. (1994). Violent behavior by individuals with serious mental illness. *Hospital Community Psychiatry, 45*, 653–662.

Treatment Advocacy Center. (2009) Jails and Prisons. Retrieved from http://www.treatmentadvocacycenter.org/resources/consequences-of-lack-of-treatment/jail/1371.

Trochim, W. (2006). *Qualitative measures*. Retrieved from http://www.socialresearchmethods.net/kb/qual.php.

www.manaraa.com

United States v. Georgia. 2009 Case No. 1:09-cv-00119- CAP (January 15, 2009).

University of Illinois National Research and Training Center on Psychiatric Disability. (2008). *Self-determination*. Retrieved from http://www.psych.uic.edu/UICNRTC/sdframework.pdf.

Union Pac. R.R. Co. v. Botsford, 141 U.S. 250, 251 (1891).

University of Washington School of Medicine. (2009). *Ethics in medicine*. Retrieved April 5, 2009, from Informed Consent Web site: http://depts.washington.edu/bioethx/topics/consent.html#ques1.

U.S. Department of Health and Human Services. (1999). *Mental health: A Report of the Surgeon General—Executive summary*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Legal Definitions. (2012).Social contract law and legal definition. http://definitions.uslegal.com/s/social-contract-theory/.

van Manen, M. (1997). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). London, Canada: Althouse Press.

Virginia Acts of Assembly—2010 Session. Chapter 550. (2010). Retrieved from http://leg1.state.va.us/cgi-bin/legp504.exe?101+ful+CHAP0550+pdf

Virginia Association of Community Services Boards. (2012). 2012 Overview of community services in Virginia. Retrieved from http://vacsb.org/Misc/CSB_Overview_2012.pdf.

Virginia Department of Criminal Justice System (nd). About DCJS. Retrieved from http://www. http://www.dcjs.virginia.gov/about/.

www.manaraa.com

Virginia Judicial System. (2009). *Virginia courts in brief*. Retrieved from http://www.courts.state.va.us/.

Vuchovick, P. (2000). The ethics of involuntary procedures. *Perspectives in Psychiatric Care*, *36*, 111–112.

Wahl, O. F., Wood, A., & Richards, R. (2002). Newspaper coverage of mental illness: Is it changing? *Psychiatric Rehabilitation Skills*, *6*, 9–31.

Walsh, E., Buchanan, A., & Fahy, T. (2002). Violence and schizophrenia: Examining the evidence. *British Journal of Psychiatry*, *180*, 490–495.

Wand, T. (2012). Positioning mental health nursing practice within a positive health paradigm. *International Journal of Mental Health Nursing.* Retrieved from doi: 10.1111/j.1447-0349.2012.00848.x.

Warren, L., Mullen, P., Thomas, S., Ogloff, J., & Burgess, P. (2008). Threats to kill: A follow-up study. *Psychological Medicine*, *38*, 599–605.

Watson, A., Corrigan, P., & Angell, B. (2005). What motivates public support for legally mandated mental health treatment? *Social Work Research*, *29*, 87–94.

Watson, A., Morabito, M., Draine, J., & Ottati, V. (2008). Improving police response to persons with mental illness: A multi-level conceptualization of CIT. *International Journal of Law and Psychiatry*, *31*, 359–368.

Watson, A., Ottati, V., & Corrigan, P. (2003). From whence comes mental illness stigma? *International Journal of Social Psychiatry*, *49*, 142–157 doi:10.1177/0020764002049002007.

Wilk, R. (1988). Involuntary outpatient commitment of the mentally ill. *Social Work*, *3*, 133–137.

www.manaraa.com

Wilk, R. (1994). Are the rights of people with mental illness still important? *Social Work, 39*, 167–174.

Williams, C., & Arrigo, B. (2002). Law, psychology, and the "new sciences": Rethinking mental illness and dangerousness. *International Journal of Offender Therapy and Comparative Criminology, 46*(1), 6–29. doi:10.1177/0306624X02461002.

Willigenburg, T. (2005). Protecting autonomy as authenticity using Ulysses contracts. *Journal of Medicine and Philosophy*, *30*, 395–409.

Woods, P., Reed, V., & Collins, M. (2003). The relationship between risk and insight in a high-security forensic setting. *Journal of Psychiatric and Mental Health Nursing*, *10*, 510–517.

Wyatt, R. (2001). *An interview with Thomas Szasz, MD: Liberty and the practice of psychotherapy*. Retrieved from www.psychotherapy.net/interview/Thomas_Szasz.

Youngberg v. Romeo, 457 U.S. 307 (1982).

Zanni, G., & Stavis, P. (2007). The effectiveness and ethical justification of psychiatric outpatient commitment. *American Journal of Bioethics*, *7*, 31–41.

Zemishlany, J. (2007). Involuntary hospitalization and treatment: The interface between psychiatry and law. *Harefuah, 146*, 602–604, 646.

www.manaraa.com

Appendices

Appendix A

Introduction Letter to Gatekeepers

I am a PhD student in the School of Social Work at Virginia Commonwealth University and a LCSW who treats individuals and families who have experienced civil detainment. I am writing to you because you are licensed and may be treating clients with related backgrounds, specifically civil detainment.

Under the direction of Dr. Mary Secret, Associate Professor, VCU School of Social Work, I am conducting a qualitative research study to explore the experiences of individuals who have undergone detainment after July 2008. For the purposes of the study, I am interested in the experiences with a civil detainment hearing. This research is being done as part of my program as a doctoral student in the School of Social Work at Virginia Commonwealth University in Richmond, Virginia.

I am inviting you to consider your caseload and identify clients who have experienced civil detainment and would be willing to share their experiences in a confidential interview with me. To be eligible, participants must have experienced a civil detainment, otherwise known as an emergency custody order (ECO) or temporary detainment order (TDO), after July 2008. During the interview, I will ask questions such as the following:

Would you share your feelings, thoughts, and understanding of civil detainment law?

- Is/was there a sense that you, your family, or the community is more or less safe?
- A feeling of fear?
- A Feeling of relief?

Would you share your experiences with civil detainment?

www.manaraa.com

- *A sense of dangerous or in danger?*
- *Increased anxiety, a fear of re-detainment or future involvement?*
- *Perception of mental health services?*

Would you share how the experience of civil detainment has affected or not affected your perception of yourself or individuals with mental illnesses?

- *How would you describe individuals with mental illness?*
- *What were you feeling in terms of dignity, respect and recovery during the process of civil detainment?*
- *Stigmatized?*
- *Vulnerable?*
- *Was your employment affected?*

If you identify someone who meets criteria, please share the enclosed information and if he/she expresses interest, have him/her sign an initial release of information so that you can communicate his or her name and contact information to me. I will then follow up with him/her with further information about the research project and obtain his or her formal consent to participate in this study. This manner of communicating with him/her will ensure participants' anonymity. If you have any questions, please contact me.

Thank you for your time and consideration of this study.

Mary Secret, PhD
School of Social Work
Virginia Commonwealth University
Richmond, VA 23229
804-828-1020
mcsecret@vcu.edu

Linda E. Love, LCSW
P.O. Box 782
Sandston, VA 23150
804-428-8526
lovele@vcu.edu

www.manaraa.com

Appendix B

VCU IRB Protocol HM13574

Multiple Perspectives on the Lived Experience of Civil Detainment:

Recruitment Script
(to be used by third party)

Hello,

Linda Love, LCSW, a PhD candidate in the School of Social Work at Virginia Commonwealth University and Mary Secret, PhD, faculty, are conducting a qualitative study exploring the experiences of individuals who have undergone the process of detainment leading up to or through a civil commitment. This research will consist of an interview that will require approximately 60 minutes of your time, sharing your experiences and then verifying that your information accurately reflected. If you agree to participate in this study, the researchers will contact you to discuss your consent and to schedule your interview at a time and location of your choice. Your participation in this study is voluntary; you can terminate your participation at any time during the research process.

Financial compensation is not offered as part of this study. If you are not interested in participating, you will not suffer any effects on the treatment that you are receiving. If you would like to hear more about the project, please sign the Release of Information Form, and I will give the information to the researcher, who will contact you.

www.manaraa.com

Appendix C

Permission to Release Contact Information

I give permission to _____ (Referral Source) to release my name and contact information to the research staff of VCU IRB protocol HM13574,

Title: Multiple Perspectives on the Lived Experience of Civil Detainment

I give my permission to release to the VCU researcher my:

☐ First Name (specify): _____

AND (at least one of the following)

☐ Phone Number (specify): _____

☐ Alt Phone Number (specify): _____

☐ Email Address (specify): _____

_____

Print Name Signature

_____

Date

www.manaraa.com

Appendix D

Research Subject Information and Consent Form

TITLE: Multiple Perspectives on the Lived Experience of Civil Detainment

VCU IRB NO: HM13574
You may take an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

PURPOSE OF THE STUDY
The purpose of this constructivist inquiry will be to 1) satisfy dissertation requirements for the Doctor of Philosophy in Social Work and 2) explore and understand the effects of civil detainment leading up to civil commitment on human dignity. The goal will be to clarify concepts, gain insight, and explore the experiences of individuals who have experienced civil detainment directly or indirectly.
You are being asked to participate in this study because you have experienced detainment related to a potential civil commitment hearing.

DESCRIPTION OF THE STUDY AND YOUR INVOLVEMENT
If you decide to participate in this research study, you will be asked to sign this consent form after you have had all your questions answered and you understand what will happen. In this study, you will be asked to participate in interviews in which you will be asked about your experiences with detainment due to a request for a civil commitment hearing. This will entail sharing your story about feelings and perceptions about the experiences and the impact they may have on your dignity. The interview will last approximately 60 minutes. During the interview, detailed notes will be taken so that your experiences can be accurately gathered, but your name will not be recorded on the transcript. You will have an opportunity to review the information that has been gathered to ensure that your information has been accurately reflected.
This study will involve approximately 25 participants representing a wide range of stakeholders associated with civil commitment in the Commonwealth of Virginia. Study results will be provided to you upon request.

RISKS AND DISCOMFORTS
Sometimes, talking about the subjects that are the focus of this research causes people to become upset. If you become upset, the research staff will give you opportunities to discuss and share your feelings. It is not unusual for an inquiry of this kind to present new ways of thinking about a phenomenon. The questioning of one's beliefs can be stressful.

BENEFITS TO YOU AND OTHERS
Your participation will benefit others by helping social workers to learn about the experiences of civil detainment. This information may help develop appropriate services for other individuals

www.manaraa.com

who will experience civil detainment in the future. You may request a copy of the study report by mailing back the attached stamped self-addressed letter give to you by the researchers.

COSTS
There are no costs for participating in the study, other than the time you will spend in the interview.

CONFIDENTIALITY
The researchers will treat your identity and all information about you with professional standards of confidentiality. The non-identifying information you provide will be used to write the case study report. The researchers may publish information obtained in this study, but the researchers will not reveal your identity to anybody else. The researchers will keep all records of the research with identifying numbers rather than using your name in a locked research storage area.

IF AN INJURY HAPPENS
Virginia Commonwealth University and the VCU Health System (also known as MCV Hospital) do not have a plan to give long-term care or money if you are injured because you are in the study. If you are injured because of being in this study, tell the staff right away. The study staff will supply you with a list of referrals for you to access.

VOLUNTARY PARTICIPATION AND WITHDRAWAL
You do not have to participate in this study. If you choose to participate, you may stop at any time without any penalty. Your involvement in this study will not affect your continued involvement in treatment with the referral source. You may also choose not to answer particular questions that are asked in the study.

QUESTIONS
In the future, you may have questions about your participation in this study. If you have any question, complaint, or concern about the research, contact:

Mary Secret, PhD
School of Social Work
Virginia Commonwealth University
Richmond, VA 23229
804-828-1030
mcsecret@vcu.edu

Linda E. Love, LCSW
P.O. Box 782
Sandston, VA 23150
804-428-8526
lovele@vcu.edu

If you have questions about your rights as a participant in this study, you may contact:
Office for Research
Virginia Commonwealth University
800 Leigh Street, Suite 113
P.O. Box 950568
Richmond, VA 23298
Telephone: 804-827-2157

www.manaraa.com

You may also contact this number for general questions, concerns, or complaints about the research. Please call this number if you cannot reach the research team or wish to talk to someone else. Additional information about participation in research studies can be found at http://www.research.vcu.edu/irb/volunteers.htm.

CONSENT

I have been given the chance to read this consent form. I understand the information about this study. Questions that I wanted to ask about the study have been answered. My signature says that I understand as a participant in this study:

- My participation is voluntary. I can choose to quit at any time.
- Any information on my health status will not be revealed to anyone by the researchers.
- The researcher will interview me and the interview is confidential.
- The researchers will not reveal my identity in any publication or report written about this study.
- I will receive a copy of the consent form once I have agreed to participate.

Participant name—printed	Participant signature	Date

Researcher name—printed	Researcher signature	Date

www.manaraa.com

Appendix E

Interview Protocol HM13574

Interview Protocol: The Multiple Perspectives of Civil Detainment

This protocol is to be read aloud by Linda. Headings will not be read aloud.

INTRODUCTION

Good morning/afternoon/evening and thank you for taking the time to participate in this interview. My name is Linda Love LCSW, and I am a PhD student at Virginia Commonwealth University in Richmond. I am conducting this study under the supervision of my faculty mentor, Dr Mary C. Secret, to learn more about the experiences of people who have experience civil detainment. As part of this study, I am interviewing individuals with who have been detained after July 2008 to learn about their experiences and who have been involved in various aspects of the civil detainment process. The information collected in these interviews will help me to build an understanding of the experience of civil detainment.

THE INTERVIEW PROCESS

As indicated in the consent form, I will take notes during the interview, but your personal information will be de-identified in the notes. The interview should take forty-five to sixty minutes. You can skip any questions you do not want to answer, and you can stop participating at any time. Please feel free to share your point of view; I am interested in all of your comments, positive and negative. Following are questions that may be asked.

Would you share your feelings, thoughts, and understanding of civil detainment law?

- Is/was there a sense that you, your family, or the community is more or less safe?
- A feeling of fear?
- A Feeling of relief?

Would you share your experiences with civil detainment?

- *A sense of dangerous or in danger?*
- *Increased anxiety, a fear of re-detainment or future involvement?*
- *Perception of mental health services?*

Would you share how the experience of civil detainment has affected or not affected your perception of yourself or individuals with mental illnesses?

www.manaraa.com

- *How would you describe individuals with mental illness?*
- *What were you feeling in terms of dignity, respect and recovery during the process of civil detainment?*
- *Stigmatized?*
- *Vulnerable?*
- *Was your employment affected?*

During the interview and the research study, you will be offered opportunities to verify and clarify the information that is being gathered.

www.manaraa.com

Appendix F

VCU IRB Protocol HM13574

Multiple Perspectives on the Lived Experience of Civil Detainment:

Recruitment Script

Interested in Participating in Research on Civil Detainment?

I would like to let you know about an interesting research project conducted by a researcher, Linda Love LCSW PhD Candidate from Virginia Commonwealth University (VCU). This study will explore civil detainment. Individuals who have been involved in various aspects of the civil detainment process will be interviewed. The researcher is interested in hearing about your experiences with civil detainment.

This research will consist of an interview that will require approximately 60 minutes of your time, sharing your experiences and then reviewing the information afterwards for accuracy. Financial compensation is not offered as part of this study. Your decision about whether to be in the study or not will not affect your employment in any way. The study is totally separate from your employment.

If you would like to hear more about the project, please contact me at:

Linda Love LCSW PhD Candidate
804-221-6682
804-428-8536
lovele@vcu.edu

www.manaraa.com

Appendix G

FINAL MEMBER CHECK QUESTIONS
#HM13574

Name: _____

- Is your perspective accurately reflected in the case study?

- Did you gain new understanding about the experience of civil detainment from others' perspective?
  If yes, explain. If no, please explain.

- Are there factual or interpretive errors? Please be specific.

- Are there any comments you would like to make?

www.manaraa.com

Appendix H

Auditor's Report
MULTIPLE PERSPECTIVES OF THE LIVED EXPERIENCE OF CIVIL DETAINMENT
Linda Love
Audit Conducted by Monica Leisey
January, 2012

Purpose of the Audit

The purpose of this audit is to assess the rigor of Linda Love's final report for her dissertation entitled: *Multiple Perspectives of the Lived Experience of Civil Detainment.* Assessing the rigor of a constructivist inquiry requires examining the trustworthiness constructivist process and authenticity of the final report. Each of the dimensions of trustworthiness, confirmability, credibility, dependability, and transferability were assessed for this audit. The dimensions of authenticity assessed include fairness ontological and educative authenticity. The guidelines for performing this audit were constructed from *Naturalistic Inquiry* (Lincoln & Guba, 1985), Linking Auditing and Metaevaluation (Schwandt & Halpern, 1988) and Social Work Constructivist Research (Rodwell, 1996).

Preparing for the Audit

Linda asked me to serve as her auditor via email as she began the dissertation process. In December, 2011 she contacted me to let me know that she was ready for me to conduct the audit. Having done the majority of her analysis using INVIVO, she was able to send me a link to the software, where her data and journals were stored electronically. She was also able to send me via email her final report.

Process:

The audit process included reading the final report, randomly selecting 10 superscripts, tracking the superscripts back through INVIVO identifying the node to which the superscript was connected, tracing the individual codes within each node to the raw data as it was entered into INVIVO, reading the methodological journal, reading the reflexive journal, and reading the peer-review journal. All three journals were included in the INVIVO software.

Statement of Findings

Trustworthiness

Confirmability of a constructivist inquiry is whether or not the final report is grounded in data and that inferences were logical. I assessed this dimension of rigor by tracking the superscript superscripts within the final report through INVIVO to the raw data as it was typed into the software. Ten superscript superscripts were chosen at random from the final report. For each of the 10 superscripts, the first 5 coded data units were tracked through the INVIVO software for a total of 50 coded entries being tracked. From these

www.manaraa.com

findings, I can assert that the final report is grounded in the data. Additionally I can assert that the category structure, referred to as nodes within the NVIVO software, are logical and explanatory.

Credibility of a constructivist inquiry is the ability of the inquirer to accurately capture the participants' perspectives in the final report and the ability of the inquirer to provide an emic, or insider's view point in a way that is believable. Triangulation is a strategy often used to crosscheck the findings within the final report to the multiple data sources included. Through my extensive readings of the final report, reflective journals, and member checking file, I am confident that the inquirer was able to provide an emic viewpoint that reflects the multiple perspectives of the participants. The final report is written in a way that explicates the visceral experiences of the participants and this is solidified in the comments provided by those who participated in the member checking process.

Dependability is the assertion that shifts occurring throughout the inquiry process were appropriate to the constructivist inquiry process. I was able to identify a number of methodological shifts that occurred during the inquiry process. Based on the data provided in the peer-review journal, the methodological journal, and the reflexive journal these shifts were completely in line with the intent and purpose of this inquiry. Furthermore, the changes described emerged from the organic process of the inquiry and were prompted by the experience of the inquirer with the participants. There is no evidence of the inquirer making ungrounded changes.

Transferability is the assertion that the information and lessons learned provided in the final report may be useful in other similar contexts. This is often evidenced by the thick description used in the writing of the final report and the emic perspective provided in the final report. Based on the member check feedback provided, and the inclusion of multiple perspectives firmly grounded in the data gathered, I believe that the tentative lessons learned may be appropriate and informative to others interested in the lived experience of civil detainment.

Authenticity

Fairness within a constructivist inquiry refers to the balancing of all viewpoints within the final report, demonstrating the inquirer's ability to incorporate different perspectives, experiences, and understandings. Essentially, each participant in the process has a voice that is heard. Based on the multiple perspectives incorporated into the final report, which are firmly grounded in the data, and the member checking feedback, I am confident that the inquirer provided opportunities for all perspectives and experiences to be heard.

Educative and ontological authenticity include a better understanding of the complexity of the phenomena being explored, was evidenced in the reflexive journal provided for the audit. A number of entries focused on new levels of awareness that the inquirer had about her past work experiences and the realization that perhaps she had not been as aware of

www.manaraa.com

> some of the possible consequences of her actions at the time. While educative and ontological authenticity of participants were not explicitly identifiable within the data shared, it is clear that the inquirer gained a better understanding of the lived experience of civil detainment and an appreciation for the inherent complexity of the many possible meanings of the phenomena.

Based on the thorough examination of the audit trail provided to me, I can warrant the confirmability, credibility, dependability, transferability, fairness, ontological and educative authenticity of this constructivist inquiry .

"Monica Leisey, PhD, MSW
Salem State University School of Social Work

www.manaraa.com

Appendix I

Curriculum Vitae Justin Scott Lee
Wilson, NC 27896
(509) 481-3633
jslee@barton.edu

EDUCATION

Doctor of Philosophy, (Candidate) **Virginia Commonwealth University, School of Social Work.** Dissertation Defense: April 13, 2012
Dissertation: *Unaccompanied Refugee Minors and the Strategies they Use to Navigate in a New World: A Grounded Theory Approach*
Chair: Dr. Pamela J. Kovacs
Master of Social Work, Eastern Washington University. June 2007
Bachelor of Science (Sociology) , Brigham Young University. August 2005

SCHOLARSHIP

Publications

Kovacs, P. J., & **Lee, J.** (2010). Developing a community-university partnership for intergenerational programming: Relationship building is key. *Journal of Intergenerational Relationships, 8*(4), 406-411.

Forthcoming Articles

Weng, S. & **Lee, J.** Identifying challenges and offering solutions to difficult to access populations.
Target journal: *Nonprofit and Voluntary Sector Quarterly*
Target date for submission: April 30, 2012

Lee, J. Unaccompanied Refugee Minors: A review of the literature.
Target journal: *Journal of Immigrant and Refugee Studies*
Target date for submission: June 1, 2012

Lee, J. A strengths-based approach to adolescent refugee resettlement: Applying Ungar's Resilience Across Culture framework.
Target journal: *International Journal of Social Welfare*
Target date for submission: August 1, 2012

Prospective Funding

The Silberman Faculty Grant Program: The New York Community Trust
$20,000 per year, two years—Immigration, understanding and meeting the needs of diverse immigrant groups
Application deadline: April 30, 2012

Professional Presentations

www.manaraa.com

Access: Identifying and Sampling Immigrant and Identity-Based Nonprofits—
ARNOVA, Toronto, Canada
November 2011

Unaccompanied Refugee Minors and their Strategies to Navigate a New World: A Grounded Theory—
Council on Social Work Education, Atlanta, GA
October 2011

Acculturation, Risk, and Well-Being among Unaccompanied Refugee Minors: A Review of the Literature and Future Research Agenda—
International Conference on Social Work, Los Angeles, CA
March 2011

Negotiating and Designing an Intergenerational University-Community Partnership—
Council on Social Work Education, San Antonio, TX
November 2009

APA Style and Social Work Scholarship—
VCU School of Social Work, Richmond, VA
October 2008

Poster Presentations
Unaccompanied Refugee Minors in Virginia: A Review of the Literature and Implications for Practice and Research—
VCU Graduate Research Symposium, Richmond, VA
April 2011

From Policy to Practice: The Influences on Service Provision to Unaccompanied Refugee Minors—
NASW-VA Annual Conference, Richmond, VA
March 2011

Peer Reviewer / Auditor
Auditor: Monico, C. Dissertation: Intercountry adoption from the perspective of sending countries
March, 2012—Current

Auditor: Weng, S. Dissertation: Founders of nonprofit agencies serving immigrants
January, 2012—Current

Peer Reviewer: Love, L. Dissertation: Policy experience with involuntary detainment
August, 2011—February, 2012

Invited Trainings
The Attachment Process in Unaccompanied Refugee Minors—Foster Parents Pre-Service

www.manaraa.com

and In-Service, Commonwealth Catholic Charities, Richmond, VA
June 2010; September 2010; March, 2011

TEACHING

BSW Courses
Social Work & Oppressed Groups
Fall 2009; Fall 2010
Communication in the Helping Process
Spring 2010; Spring 2011
Foundations of Social Work Research I
Spring 2010
Social Work Practice: Fundamentals
Summer 2010; Spring 2011
Social Work Practice: Families and Groups
Fall 2011
Race and Ethnic Relations
Fall 2011: Spring 2012
Introduction to Social Work
Fall 2011: Spring 2012
Society and the Social Experience
Spring 2012

SERVICE

Community and University Service
Presentation to the faculty: *Strategies and Challenges in Developing Community-University Research partnerships*
February 28, 2012
Advisor to the Hamlin Society—Barton College Student Social Work Club
February 2012—Current
Library Committee: Social Work Faculty Representative—Barton College Library
August 2011—Current
Volunteer Mentor—Commonwealth Catholic Charities, Unaccompanied Refugee Minor Program
May 2010—August 2011
Promotion and Tenure Committee Member, PhD Student Representative
September 2008—January 2009; January 2010—April 2010
Grade Appeal Committee
August 2009—November 2009; March 2009—May 2009

Service to the Profession
National Conference Volunteer: Society for Social Work Research
January 2008, January 2009
National Conference Volunteer: Council on Social Work Education
October 2008, October 2009, October 2010

www.manaraa.com

PROFESSIONAL EXPERIENCE

Investigator on funded project: BEL grant for infusing gerontology into curriculum:
Dr. Pamela J. Kovacs
September 2010—Current
Graduate Research Assistant to Associate Professor in the School of Social Work:
Dr. Pamela J. Kovacs
September 2008—May 2010
Graduate Research Assistant to the Associate Dean for Community Engagement:
Dr. Timothy L. Davey
September 2007—May 2008

PRACTICE EXPERIENCE

Post MSW

In-Home Counselor—Hallmark Youthcare of Richmond
Richmond, Virginia, May 2008—March 2009

- Provide in-home psychotherapy to children and adolescents and families when returning home from residential care.
- Facilitate group therapy seasons of 10-15 adolescents on substance abuse, anger management, and social skills.
- Was selected as *Employee of the Quarter* for going beyond what was required in providing excellent service to marginalized populations.

Program Therapist—Hallmark Youthcare of Richmond
Richmond, Virginia: March 2009—December 2009

- Provide psychotherapy to adolescents in residential treatment facility.
- Engage in therapy sessions with residents and their families.
- Facilitate group therapy in a variety of

In-Home Counselor—Hallmark Youthcare of Richmond
Richmond, Virginia, December 2009—February 2011

- Provide in-home counseling for adolescents and families when adolescents return home from residential care.

Pre MSW

Human Service Worker—Wasatch Mental Health
Provo, Utah, July 2002 – July 2005

- Selected to begin new program working with high-risk teenagers.
- Chosen to interview and train new employees the use of behavior modification techniques.
- Taught social skills to children with social emotional challenges and

www.manaraa.com

developmentally disabled and teens.
International Orphanage Director— Casa de Sion
Guatemala City, Guatemala, January 2005 – May 2005

- Directed all local orphanage affairs including employees, legal action in cases of children, medical and vaccination, well-being of children and all distribution of orphanage finances.
- Successfully instituted token economies, reward systems and positive reinforcement as behavior modification tools.
- Consulted with professionals from social services, medical, legal and international support teams.

Therapist Intern—Spokane Child Abuse and Neglect Prevention
Spokane, Washington, April 2006 – June 2007

- Facilitated and co-facilitated the Nurturing Fatherhood group.
- Provided therapy, case management and parent education to individuals, children, families and community groups.
- Participated in case conferencing as a member of a community based multiple disciplinary team.

PROFESSIONAL AFFILIATIONS

National Association of Social Workers
Council on Social Work Education

www.manaraa.com

Appendix J

Monica R. Leisey
Office: **Home:**
Salem State University 26 New Derby St
School of Social Work Apt. 402
352 Lafayette St. Salem, MA 01970
AB011
Salem, MA 01970 **Email:** Leiseymr@vcu.edu
978-542-6553 978-594-0119;
Cell: 804-399-2657

PROFESSIONAL OBJECTIVES

Professional Goal: To be part of a community of academics, service providers and community members responsible for the creation of a socially just response to the problem of domestic violence. Dedicated to learning with and from each other, and willing to demand the restructuring of our social welfare and safety net systems for casualties of relational violence, this community will treat fairly and provide equal access to opportunities and resources to all clients, regardless of their role in the violent episode.

Research Interests: Exposing and understanding the structural and cultural barriers to social justice including the complex interplay of gender, race, and class; specifically at the integration of ageing and domestic violence.

Teaching Interests: facilitating the growth and development of critical practitioners who understand the inherent overlap between research and practice at all levels. I hope to have opportunities to combine critical pedagogy, non-oppressive teaching, and experiential learning in research and practice classes.

education

Doctor of Philosophy – Social Work Graduated – May 2007
Virginia Commonwealth University (Richmond, VA)
Dissertation Title: A Constructivist Inquiry into the meaning of the term Domestic Violence
Dissertation Chair: Mary Katherine O'Connor, PhD, MSW

Preparing Future Faculty Certificate Certificate awarded – May 2006
Virginia Commonwealth University (Richmond, VA)

Master of Social Work Graduated – May 2002
Virginia Commonwealth University (Richmond, VA)
Concentration: Planning & Administration

Bachelor of Arts Graduated – August 1988
University of North Carolina-Greensboro (Greensboro, NC)
Major: History

www.manaraa.com

Academic Experience

Assistant Professor September, 2010 – present
School of Social Work, Salem State University
Tenure Track
Teaching load: 3-4 with field liaison responsibilities
Research agenda focus: intersection of domestic violence and elder abuse

Social Work Experience

Coordinator for Research March, 2009 – July, 2010
Institute for Women's Health, VCU
Creating a five year strategic plan for the Institute regarding research in the area women's health
Establishing a mentorship program that will link senior researchers with new investigators in the area of women's health, increasing VCU's expertise in women's health research
Developing the research infrastructure within the Institute of Women's Health that will enhance VCU's ability to create interdisciplinary and translational research cooperatives able to secure both federal and foundation research funding support

Reaccreditation Assistant June, 2009 – July, 2010
VCU School of Social Work
Analyzed evaluation data
Assisted with documentation and synthesis of program data
Assisted with the development of the alternative project appeal

Project Coordinator May, 2008 – October 2008
Family and Children's Trust Fund – VCU Social Indicator Project
Extensively interviewed stakeholders in the family violence response community to assess the logistics and feasibility of creating a state report card for family violence
Created a conceptual framework for the creation of a state report card on family violence including two dimensions: the state of family violence and the state of our response to the violence
Developed a consortium of stakeholders to work on the implementation of the family violence report card plan
Created the first annual report for the Project

Social Work Informationist February 2006 – February 2008
Tompkins-McCaw Library for the Health Sciences
Developed and implemented the Journey Project framework and plan
Created the Journey Notebook, a tool to facilitate the organization of health information for cancer patients
Completed certification as community health education specialist
Provided health information and consultation to cancer patients
Provided health information and consultation in the Community Health Education Center
Presented health information access training to seniors in the community

www.manaraa.com

Acting Coordinator October 2004 – January 2005
Central Virginia Older Battered Women's Task Force
Provided project continuity during the search and hiring process for a new coordinator
Conducted extensive literature reviews for continuing projects
Continued efforts to work collaboratively with Central Virginia Agencies which serve women over the age of 50 who may be experiencing domestic violence situations
Drafted two small grants for outreach opportunities for the task force
Developed innovative outreach plans for the Asian-American population and the Hispanic-American population within the Task Force's service area
Wrote an extension of the research protocol and IRB submission for the Older Battered Women Focus Group project

Acting Coordinator November 2003 – April 2004
Chesterfield County, VA Domestic Violence Resource Center
Provided office continuity and supervision during the 6 month search and hiring process for a new coordinator
Provided supervision of two direct-service county employees working with domestic violence survivors within the criminal justice system
Continued collaborative efforts at local, regional and state levels for domestic violence intervention and education
Drafted successful Violence Against Women Act grant refunding proposal
Completed and Submitted 501c(3) application for the Chesterfield County Domestic Violence Task Force

Child Advocate June 2003 – January 2004
Project Hope, Quinn Rivers, VA
Provided comprehensive counseling to children and adolescents exposed to domestic violence within both a school and agency setting
Carried a case load of approximately 30children
Developed a state-of-the-art anger-management and sexual assault curriculum for adolescents to be used with an existing after school program

Administrative Coordinator June 2003 – December 2003
Batterers Intervention Program, Certification Board, VA
Supervised a comprehensive revision of the Virginia Batterers Intervention Program Certification standards congruent with national standards
Documented all board meetings, activities and communication
Planned and organized all Virginia Batterers Intervention Program Certification Board Meetings

Graduate Internship August 2001 – May 2002
Chesterfield County Domestic Violence Resource Center
Conducted an assessment of program quality
Developed a multi-disciplinary collaboration assessment tool
Reviewed current and ongoing research related to danger assessment and domestic violence

www.manaraa.com

Developed Danger Assessment training
Provided Danger Assessment training to community service providers
Developed County Resource Guide

Graduate Internship August 2000 – May 2001
Communities in Schools
Provided individual and group counseling to adolescents at risk
Coordinated Community in School team meetings

Other Work experience

Corporate Secretary and Treasurer 1997 - 2000
Data Resource Management, Inc., Richmond, VA
Facilitated in developing strategic plans for rapidly growing healthcare consulting company
Independent Financial Planner 1996 - 1997
USPA&IRA, Colonial Heights, VA
Assisted clients in lifetime planning for financial independence
Managed over 230 active accounts and two employees

Grants Awarded

Violence Against Women Act (VAWA), Training Grant, November, 2012 - Present
Worked collaboratively with community partners to write and submit grant
Responsible for measurement tools for individual trainings
Responsible for measurement tool for over-all evaluation of the grant process
Salem State University, Center for Teaching Innovation, Adjunct Faculty Learning Community Award May, 2011 – Present
Worked with faculty to explore efficient and effective ways to implement student assessment for field/service learning experiences
Developed and implemented research project designed to assess the importance of understanding assessment criteria for MSW field interns
Salem State University, Research Seed Grant, Planning for a Comprehensive Interdisciplinary Geriatric Center at Salem State University
Award December, 2011 - Present
Worked collaboratively with an interdisciplinary group of professors
Developing a Geriatric Education Center HRSA Grant
Virginia Commonwealth University, Center for Teaching Excellence, Engaging in the Scholarship of Teaching and Learning Faculty Learning Community
Award August, 2008 – November 2011
Worked collaboratively with an interdisciplinary group of professors
Developed a group project exploring the scholarship of teaching and learning
Virginia Commonwealth University, Center for Teaching Excellence, Adjunct Faculty Learning Community Award August, 2007 – September, 2011
Worked with other adjunct instructors to explore the experiences of adjunct instructors at VCU

www.manaraa.com

Developed research project to describe VCU adjunct instructors and to understand their support needs and teaching experience
Information Rx Evaluation Project, Co-Principal Investigator
VCU, Tompkins-McCaw Library for the Health Sciences August 2005 – March 2006
Funded by National Medical Library (unsolicited award)
Developed research method and design
Co-wrote submission for National Medical Library Funding
Collected and analyzed qualitative and quantitative data
Department of Health and Human Services, National Institutes of Health, National Library of Medicine, Research Fellowship Award July, 2005 – January 2008
Developed hybrid social work informationist position
Developed practicum program within Massey Cancer Center
Developed evaluation research method and design including qualitative and quantitative dimensions of assessment

research experience

Incorporating metacognition into an MSW research course,
Principle Investigator May 2011 – Present
Salem State University, School of Social Work
Developed the mixed method research design
Implemented the course change
Measured and analyzed changes in metacognition

Community Engagement Impact Assessment,
Co-Principle Investigator September 2009 – 2011
VCU, Institute of Women's Health
Collaborated on research method and design
Responsible for IRB submission
Responsible for analyzing qualitative data
Responsible for analyzing quantitative data
Exploring Professional's Preparedness: Responding to Abuse Among Older Adults, Co-Principle Investigator July 2009 – 2011
VCU, Institute of Women's Health
Developed research method and design
Responsible for analyzing qualitative data
Responsible for analyzing quantitative data
The VCU Adjunct Study, Co-Principal Investigator March 2008 – 2011
VCU, Center for Teaching Excellence
Developed research method and design
Collaborated in creation of an internet survey
Analyzed qualitative data
Assisted in analysis of quantitative data
Accessing Quality Health Information on the Internet,
Co-Principal Investigator May 2007 – March 2008
VCU, Tompkins-McCaw Library

www.manaraa.com

Developed research method and design
Created assessment tool
Responsible for collecting and analyzing qualitative and quantitative data
The Multiple Meanings of Domestic Violence: A Constructivist Inquiry,
Co-Principal Investigator; Dissertation Research April 2005 – May 2007
VCU School of Social Work
Developed research method and design
Collected and analyzed qualitative data
Social Justice Curriculum Evaluation,
Co-Principal Investigator March 2005 – September 2006
VCU, MSW Social Justice Curriculum Workgroup
Developed research method and design
Collected and analyzed qualitative and quantitative data

Forensic Nursing Services: A description of forensic services provided to victims of violence in an urban emergency department,
Co-Principal Investigator November 2004 – May 2006
VCU's Institute for Women's Health National Center of Excellence
Developed data collection tool
Developed design and methods
Collected data from pre-existing medical records
Community Response to Domestic Violence in Later Life,
Co-Principal Investigator July 2003 – May 2006
Central Virginia Older Battered Women Task Force
Funded by Grant Number 03-A4145VA02 of the Virginia V-STOP program
Prepared focus group format, questions, and logistics
Co-facilitated 7 initial focus groups
Provided technical support for IRB submission for extension of project
The Be Aware Study, Co-Principal Investigator April 2005
VCU Department of Psychiatry
Funded by Grant Numbers: NIDA DA 11476
Facilitated focus group of Be Aware group participants
Analyzed qualitative data gathered from 4 focus groups
Multi-Family Group Retreat Project,
Graduate Research Assistant September 2002 – May 2003
Virginia Commonwealth University, School of Social Work
Prepared literature review
Recruiting participants from Greater Richmond area shelters and at-risk families identified by the Community in Schools program
Collected pre and post-retreat data
Assisted with data analysis and interpretation

Service
UNIVERSITY SERVICE

www.manaraa.com

Ad Hoc White Ribbon Campaign Committee October 2011 – Present
Salem State University
Committee Co-chair
Responsible for Partnerships with School of Social Work Student organizations
Scheduled Presentations from external organizational partners
Responsible for creating marketing material
Council on Teaching & Learning May 2011 – Present
Salem State University
Facilitator for Faculty Reading Circle
Collaborated on development of plan for academic year 2011-2010
VCU Honor Council August 2008 – July 2010
Attended new Honor Council training
Serve on honor council hearings
Domestic Violence Work Group September 2004 – July 2010
Virginia Commonwealth University Center of Excellence on Women's Health
Collaborate with university community members to raise awareness of domestic violence
Collaborated on development of the Forensic Nurse Examiner Team Project
Graduate Honor Council November 2003 – May 2007
VCU Academic campus
Founding Member
Served as participant for first Honor Council Hearing
Served as Vice Co-Chair of the executive Board
Community Service Associates Program June 2006 – December 2006
Partnership between School or Social Work and VCU Institute for Women's Health
Researched evidence based practice models for Statewide Domestic Violence coalition
Presented comprehensive evidence-based practice training
Proposed model for state advocacy program implementation including necessary steps for agency implementation
Virginia Commonwealth University Qualitative
Community Conference August 2005 – October 2005
Volunteer coordinator
Facilitated round table discussion

SCHOOL SERVICE
Curricula Committee September 2011 - Present
SSU School of Social Work
Actively participated in discussions concerning curriculum structure and re-visioning process
Worked with faculty to create three proposals for new curricula
Identified areas for vertical and horizontal course integration for new curricula structure

Field Liaison Committee September 2010 - Present
SSU School of Social Work
Proposed and created new field instruction macro projects for foundation and concentration year student interns
Actively participated in monthly committee meetings re: student progress and field education departmental concerns

www.manaraa.com

HBSE Sequence Committee September 2010 - Present
SSU School of Social Work
Actively participated in discussions concerning curriculum structure of the HBSE Course for the MSW program
Participating in comprehensive course review and integration with curriculum
MSW Program Committee September 2010 - Present
SSU School of Social Work
Actively participated in discussions concerning curriculum structure of the MSW program
Participating in comprehensive program review
Diversity Committee September 2010 - Present
SSU School of Social Work
Actively participated in discussions concerning conceptualization of diversity within and across the curricula
Macro Content Workgroup, School of Social Work August 2007 – July 2010
VCU School of Social Work
Actively participated in discussions concerning curriculum structure of the MSW macro program
Participated in comprehensive curricula review
Bachelor Program Committee, School of Social Work August 2007 – July 2010
VCU School of Social Work
Provided insight concerning curriculum structure of the BSW program
Participated in the assessment of the BSW curricula via portfolio reviews
Research Content Workgroup, School of Social Work August 2007 – May 2008
VCU School of Social Work
Provided conceptualization of macro curriculum to better integrate macro content into research program
Social Justice Content Workgroup, School of Social Work August 2004 – May 2007
VCU School of Social Work
Worked with faculty members to integrate social justice into larger MSW curriculum
Created measurement tool to assess the perception of the integration of social justice content into MSW course content from both student and faculty perspectives
Conducted assessment project to determine student and faculty perception of social justice content integration
Doctoral Student Association, September 2005 – September 2007
VCU School of Social Work
President
Social Justice representative
Doctoral Program Committee May 2005 – May 2007
VCU School of Social Work
Doctoral Student Association – President representative
At-Large Student representative
Social Justice Committee August 2000 – May 2005
VCU School of Social Work
School of Social Work standing committee responsible for initiating and monitoring social justice policies for the school
Served as co-chair, 2000 - 2001
MSW Student Association Representative
Curriculum Committee August 2001 – May 2002

www.manaraa.com

VCU School of Social Work
Provided student insight for the school of MSW curriculum structure
Faculty Search Committee August 2001 – March 2002
VCU School of Social Work
Reviewed over fifty applicant files for three tenure track positions at VCU
Conducted joint interviews with faculty and screened applicants for three available tenure positions

COMMUNITY SERVICE

Elder Justice Network, Greater Lynn Senior Services, Lynn, MA
September 2010 – Present
Active member focusing on the intersection of domestic violence and aging
Participated in creation of MCOA presentation on Bullying in Older Adult communities
Prepared background literature review needed for V-STOP grant submitted in partnership with the Massachusetts Executive Office of Elder Affairs
DV Transitional Housing Task Force, YWCA, Richmond, VA
February 2010 – December 2010
Active member exploring ways to shift DV service provision from Center based to Community and Client based
Virginia Commonwealth University Field Instructor August 2008 – May 2009
Supervised the field experience of a foundation Master Social Work Student
Central Virginia Older Battered Women's Task Force
September 2001 – September 2010
Worked with domestic violence providers and aging service providers to create a collaborative community response to domestic violence in the lives of older women
Worked collaboratively with a multi-disciplinary team to review and revise the mission and vision of the Task Force
Virginia Commonwealth University Field Instructor August 2006 – May 2007
Supervised the field experience of a foundation Master Social Work Student
Chesterfield County Domestic Violence Task Force September 2001 – January 2006
Member of Delta prevention project work-group
Developed a state-of-the-art primary prevention project for domestic violence
Serve on grant writing subcommittee
Batterers Intervention Program, Certification Board January 2004 – October 2004
Collaborated on implementation of BIP Standards and certification process
Responsible for reviewing certificate applications and recommending appropriateness of granting certification
Carolyn Miller Silent Auction Volunteer June 2002 – January 2004
Created and maintained an extensive donor database
Mentor for the Pregnant Teen Program September 2001 – June 2002
Provided support and mentorship at ACDC, the alternative high school in Richmond, VA
YWCA of Richmond May 1997 – January 2001
Facilitated support groups dealing with sexual assault and substance abuse at an residential rehabilitation facility
Served as Chairperson for the Annual October Awareness Memorial
Served as Team Leader for the Volunteer Advisory Committee
Performed public speaking engagements to over 1,500 high school students on date rape issues

www.manaraa.com

Local PTA Volunteer September 1995 – June 2001
Actively involved with assisting elementary school teachers
Responsible for planning and facilitating two "LunchBunch" extracurricular reading/discussion groups
Ft. Bragg "Chain of Concern" Family Support Group January 1990 – June 1993
Provided support and assistance to families having difficulty with the separation and stress during the 1st Gulf War

CONSULTATION SERVICES

Virginia Department of Health, RADAR program July 2008 – July 2010
Collaborated with a multi-disciplinary team to review the successes and challenges of the RADAR program
Actively participated in strategic planning process for the continuation of the RADAR project
Virginia Domestic and Sexual Violence Action Alliance September 2008 – September 2009
Collaborating with a multi-disciplinary team to review the current research on trauma informed interventions for domestic violence survivors
Actively participating in creating a state-wide training module
Virginia Commonwealth University, Women's Institute of Health July 2008 – March 2009
Collaborated with Virginia Department of Health and state domestic and sexual assault advocacy group to provide training for healthcare providers and domestic violence advocates re: Building a Coordinated Health Care Response to Intimate Partner Violence
Packaged health case management system for institutionalization by local domestic violence shelter programs
Assisted Virginia Commonwealth University Human Resources Department with creating a manager's guide to responding to domestic violence in the workplace
Virginia Commonwealth University, Genetics
Counseling Department November 2006 – May 2007
Using the Internet to Empower Cancer Genetic Counseling Patients
Served as consultant for master candidate in genetic counseling degree program
Thesis committee member; Master Student: Michelle Waite

Publications

JOURNAL ARTICLES

Leisey, M., Holton, V. Davey, T., (in press). An Impact Assessment of University-Community Seed Grant Programs: Positive Unanticipated Outcomes. Journal of Community Engagement and Scholarship.

Secret, M., **Leisey, M**., Lanning, S., Polich, S., Schaub, J. (2010). Faculty perceptions of the scholarship of teaching and learning: Definition, activity level and merit considerations at one university. *The Journal of the Scholarship of Teaching and Learning.*

Alvanzo, A.A.H., **Leisey, M**., Forte, J. Boykins, A., Plichta, S., Carson, S. (2010). Differences in characteristics of victims of domestic violence, sexual assault, and other interpersonal violent crimes presenting for forensic exam: gender, substances, and services. *Journal of Interpersonal Violence.*

Boykins, A., Alvanzo, A., Carson, S., Forte, J., **Leisey, M**., Plichta, S., (2010). Minority Women Victims of Sexual Violence in the Emergency Department: Disparities in Incident History. *Journal of Women's Health, 19(3),* 453-461.

www.manaraa.com

Leisey, M.R., Kupstas, P., & Cooper, A. (2009). Domestic Violence in the Second Half of Life. *Journal of Elder Abuse & Neglect, 21*(2), 141-155.
Leisey, M.R (2009). The Journey Project: Providing Health Information to Mitigate Health Disparities. *Journal of the Medical Library Association, 97*(1), 30-33.
Leisey, M.R (2009). Qualitative Inquiry and the IRB: Protection at all Costs? *Journal of Qualitative Social Work, 7*(4), 415-426.
Leisey, M.R. (2007). Viewpoints from a Social Work Information Specialist in Context: Thoughts for Consumer Health Librarians. *Journal of Consumer Health on the Internet,* 11(4), 15-22.
Leisey, M.R. & Shipman, J.P. (2007). Information Prescriptions: A Barrier to Fulfillment. *Journal of the Medical Library Association, 95*(4), 435–438.
Green, R.G., Bailey, K., Chambers, K., Claridge, R., Jones, G., Kitson, G., Leek, S., **Leisey, M.**, Vada, K., & Walker, K. (2005). The multicultural counseling inventory: A measure for evaluating social work students' and practitioners' perceptions of their multicultural competencies. *Journal of Social Work Education*.

BOOK CHAPTERS

Gordon, J A., **Leisey**, **MR**, Moriarty, LJ & Plummer, S. (2007) Evaluating the Effectiveness of Batterer Intervention Programs: Are We Asking the Right Questions? In Laura J. Moriarty and Robert A. Jerin (Eds), *Current Issues in Victimology Research, 2nd Edition*, Carolina Academic Press, Durham, NC

AGENCY PUBLICATIONS

Leisey, M., Zicafoose, K.L. (2010). Attending to the Adjunct in an Adjunct Faculty Learning Community, Richmond, VA: Center for Teaching Excellence, Virginia Commonwealth University.
Leisey, M. (2009). Family and Children's Trust Fund Social Indicator Project, Final Report. Richmond, VA: Family and Children's Trust Fund.
Leisey, M. (2003). Responding to perpetrators for safety, accountability, and change. *In Our Vision*. Richmond, VA: Virginians Against Domestic Violence.

Papers in Progress

Leisey, M., Keyser-Marcus, L., Alvanzo, A., Rieckmann, T., Forcehimes, A.A., Sepulveda, A. (in review). Examining Relationships Between Abuse History and Gender on Mental Health Symptoms in Individuals with Substance Use Disorders.

PresentatIons

INTERNATIONAL PRESENTATIONS

Leisey, M.R. (November, 2011). *The Politics of Successful Aging: Excavation or Storying?* Presentation at the 12th Annual Transforming Social Work Practice, Education & Inquiry Conference. Burlington, VT (tab)
Leisey, M. (2011, May). *On Becoming an Academician: An autoethnography*. Paper presentation at the 7th International Congress of Qualitative Inquiry. University of Illinois at Urbana-Champaign.
Leisey, M.R. (2007, April). *A Constructivist Inquiry into the Meaning of the Term Domestic Violence*. Paper presentation at the Third International Congress of Qualitative Inquiry, University of Illinois at Urbana-Champaign.

www.manaraa.com

Leisey, M.R. (2007, April). *Attending to the Politics of the "Politics of Research"*. Paper presentation at the Third International Congress of Qualitative Inquiry, University of Illinois at Urbana-Champaign.
Leisey, M.R. Cooper, A., Kupstas, P.K. (2006, November). *Domestic Violence in the Second Half of Life*. Paper presentation at the first International Conference on Violence against Women, Montréal, Quebec.
Howell, M., **Leisey, M.** Hurst, C.G. (2006, May). *Co-creating Social Justice in the Classroom: A Gadamerian Approach to Teaching*. Paper presentation at the 2nd International Congress of Qualitative Inquiry. Urbana-Champaign, Il.

NATIONAL PRESENTATIONS

Howell, M.L., & **Leisey, M.R**. (2011, October). *Does Stimulating Metacognition Improve Learning In Social Work Research Courses?* Poster presentation at the 57th Annual Council on Social Work Education Program Meeting. Atlanta, GA (tab)
Leisey, M.R., & Secret, M. (2011, October). *Research in the Classroom: Is It scholarship?* Presentation at the 57th Annual Council on Social Work Education Program Meeting. Atlanta, GA (tab)
Leisey, M. & Keyser-Marcus, L. (2011, January) Increased Family and Social Problems for Women with Alcohol and Cocaine or Opiate Dependence. Poster Presentation at the 15th Annual Conference of the Society for Social Work and Research. Tampa, FL.
Davey, T.L.,Holton, V., & **Leisey, M.R**. (2010, October). *Community Engagement Grants: What are they good for?* Poster presentation at the 56th Annual Council on Social Work Education Program Meeting. Portland, OR.
Leisey, M.R. (2010, October). *Exploring Urban Professional Preparedness in Responding to Abuse Among Older Adults.* Poster presentation at the 56th Annual Council on Social Work Education Program Meeting. Portland, OR.
Leisey, M.R. (2007, October). *The Multiple Meanings of the Term Domestic Violence: A Constructivist Inquiry.* Paper presentation at the 53rd Annual Council on Social Work Education Program Meeting. San Francisco, CA.
Leisey, M.R. & Shipman, J.P. (2007, May). *The Journey Project.* Poster presentation at the Medical Library Association Annual Meeting. Philadelphia, PA.
Leisey, M.R. (2006, May). Understanding the Problem: A Policy Analysis of the Problem of Domestic Violence. Paper presentation at The 2006 Policy Conference. Washington, DC.
Leisey, M.R. & Shipman, J.P. (2006, May). *Information Prescriptions: Real and Perceived Barriers to Fulfillment*. Poster presentation at the Medical Library Association Annual Meeting and Exhibit. Phoenix, AZ.
Cooper, A., **Leisey, M.R**., Kupstas, P. (2006, April). *What women in the second half of life have to say about domestic and sexual violence*. Poster presentation 27th Annual Meeting of the Southern Gerontological Society. Lexington, KY.
Leisey, M. (2006, March). *A Constructivist Inquiry into Domestic Violence*. Paper presentation at the 43rd Academy of Criminal Justice Sciences Meeting. Baltimore, MD.
Howell, M., **Leisey, M.** Hurst, C.G. (2006, February). *Co-creating Social Justice in the Classroom: A Gadamerian Approach to Teaching*. Paper presentation at the 52nd Annual council on Social Work Education Program Meeting. Chicago, Il.

www.manaraa.com

Leisey, M. (2006, February). *Collaborating to End Domestic violence in the Second Half of Life*. Poster presentation at the 52nd Annual council on Social Work Education Program Meeting. Chicago, Il.

Leisey, M. & Plummer, S. (2005, February). *Exploring the Paradoxes between Domestic violence Services and the Criminal Justice System*. Paper presentation at the 51st Annual council on Social Work Education Program Meeting. New York, NY.

Abell, M.L., Davey, T.L., **& Leisey, M**. (2004, January) An Evaluation of a Multiple Family Group (MFG) Weekend Retreat for At-Risk Families. Poster Presentation at the 8th Annual Conference of the Society for Social Work and Research. New Orleans, LA.

REGIONAL, STATE AND LOCAL PRESENTATIONS

Ladd, D.L. & **Leisey, M.R**. (2008, October). *Community Health Education Center (CHEC) at Five*. Paper presentation at the Annual Meeting of the Mid-Atlantic Chapter of the Medical Library Association. Morgantown, WV.

Leisey, M.R. (2007, November). *Domestic Violence in the Second Half of Life*. Paper presentation at the Intimate Partner Violence & Health Forum, Richmond, VA.

Leisey, M.R. & Shipman, J.P. (2007, November). *The Journey Project.* Poster presentation at the Annual Meeting of the Southern Chapter of the Medical Library Association. Charleston, SC.

Leisey, M.R. & Shipman, J.P. (2007, October). *The Journey Project.* Poster presentation at the Annual Meeting of the Mid-Atlantic Chapter of the Medical Library Association. Baltimore, MD.

Leisey, M.R. (2006, October). *Consumer Health Librarians and Health Literacy: Questions Yet to be Answered*. Paper presentation at the Joint Southern/Mid-Atlantic Chapters of the Medical Library Association Annual Meeting. Atlanta, GA.

Leisey, M.R. & Shipman, J.P. (2006, October). *Information Prescriptions: Real and Perceived Barriers to Fulfillment*. Poster presentation at the Joint Southern/Mid-Atlantic Chapters of the Medical Library Association Annual Meeting. Atlanta, GA.

Carson, S., Boykins, A., Alvanzo, A., Forte, J., **Leisey, M.R**., Plichta, S.. (2006, April). *Forensic Nurse Examiners Services Provided to Domestic Violence Victims*. Poster presentation 5th Annual Medical-Surgical Nursing Conference. Richmond, VA.

Leisey, M.R. Boykins, A., Forte, J., Alvanzo, A., Carson, S., Plichta, S. (2006, March). *A Description of Forensic Services Provided to Female Victims of Domestic and Sexual Violnece in an Urban Emergency Department.* Poster presentation at the Women's Health Research Day at Virginia Commonwealth University.

Leisey, M.R. Cooper, A., Kupstas, P.K. (2006, March). *Voices of Wisdom: Older Women's Perspectives of Domestic Violence* Poster presentation at the Women's Health Research Day at Virginia Commonwealth University.

Leisey, M.R. & Shipman, J.P. (2006, March). *Information Prescriptions: Real and Perceived Barriers to Fulfilment*. Poster presentation at the Women's Health Research Day at Virginia Commonwealth University.

Langhorst, D.M., **Leisey, M.R**., Svikis, D.S., Burrus, K.M. (2005, April). *Reflections: Use of focus group feedback in the Be Aware Study*. Poster presentation at the Women's Health Research Day at Virginia Commonwealth University.

Leisey, M. (2004, March). From Victim to Survivor. Presentation at the 7th Annual Graduate Research Symposium & Exhibit. Virginia Commonwealth University.

www.manaraa.com

Leisey, M.R. (2002, March). Danger Assessment: Predicting the Likelihood of Future Violent Behaviors, Its Severity, and the Expectation That It Will Escalate. Presentation given at the Coalition for the Treatment of Abusive Behaviors Quarterly Meeting. Richmond, VA.
Bailey, K., Chambers, K., Kitson, G., **Leisey, M.**, & Walker, K. (2002, April). Social Workers' Multicultural Practice Competencies II: A Comparative Study of Self-Assessments Reported by Practitioners and Students. Poster Presentation at the 5th Annual Graduate Research Symposium & Exhibit. Richmond, VA.

Guest Presentations

Leisey, M.R. (November, 2010). Critical Thinking. Presentation given at Virginia Commonwealth University HIV/AIDS Center, Richmond, VA.
Leisey, M.R. (April, 2009). The Intersection of Domestic Violence and Health Disparities. Presentation given at the Intimate Partner Violence: Assessment, Intervention, Prevention and Resources Training for Allied Medical and Mental Health Professionals, Charlottesville, VA.
Leisey, M.R. (December, 2008). Intellectual Courage. Presentation given at Virginia Commonwealth University School of Social Work Doctoral Student Association Brown Bag, Richmond, VA.
Leisey, M.R. (October, 2008). Domestic violence and crisis intervention: an uncomfortable fit. Presentation given at Virginia Commonwealth University School of Social Work Crisis intervention class, Richmond, VA.
Leisey, M.R. (August, 2008). Domestic Violence in the Work Place. Presentation given at the HR Matters Training, Richmond, VA.
Leisey, M.R. (June, 2008). FACT – VCU Social Indicator Project. Presentation given at the Conference on Community Collaboration in Preventing Family Violence, Richmond, VA.
Leisey, M.R. (March, 2008). Managed Care and Social Justice. Presentation given at Virginia Commonwealth University School of Social Work Health Policy and Social Work class, Richmond, VA.
Leisey, M.R. (September, 2007). The Multiple Meanings of Domestic Violence: A Constructivist Inquiry. Presentation given at Coalition for the Treatment of Abusive Behaviors, Richmond, VA.
Leisey, M.R. & O'Connor M.K. (August, 2007). Framing workshop. Workshop facilitated for the VCU School of Social Work entering doctoral cohort, Richmond, VA.
Leisey, M.R. & Forte, J. (February, 2007). Exploring Trauma Informed Intervention as a Tool for More Effectively Meeting the Needs of Victims of Domestic Violence. Presentation given at Virginia Sexual and Domestic Violence Action Alliance, Richmond, VA.
Leisey, M.R. (January, 2007). What is Science: The Role of Research. Presentation given at Virginia Commonwealth University Tompkins-McCaw Library for the Health Sciences Staff Training, Richmond, VA.
Leisey, M.R. (November, 2006). Constructivist Inquiry: Is bigger better? Presentation given at Virginia Commonwealth University School of Social Work Constructivist Inquiry Social Work class, Richmond, VA.
Leisey, M.R. (2005, April). Witchcraft & Ethics. Presentation given at Virginia Commonwealth University Religious Studies Introduction to Religion Class. Richmond, VA.

www.manaraa.com

Leisey, M.R. (October, 2004). Social Work & Social Justice. Presentation given at Virginia Commonwealth University School of Social Work Introduction to Social Work Class, Richmond, VA.
Leisey, M.R. (2004, February). Wiccan Spirituality and Social Work. Presentation given at Virginia Commonwealth University School of Social Work Spirituality and Social Work Class. Richmond, VA.
Leisey, M.R. (2003, March). Wiccan Spirituality and Social Work. Presentation given at Virginia Commonwealth University School of Social Work Spirituality and Social Work Class. Richmond, VA.

Teaching experience

Assistant Professor, Salem State University, School of Social Work
Spring, 2012
Human Diversity, MSW level
Field Seminar, MSW Concentration level
Designing Social Work Research, MSW level
Agency Management & Leadership Practice, MSW level

Fall, 2010:
Human Diversity, MSW level
Human Behavior and the Social Environment, MSW level
Field Seminar, MSW Concentration level

Summer, 2011
Research for Social Work Practice, MSW level
Field Seminar, MSW Concentration level

Spring, 2011
Human Diversity, MSW level
Field Seminar, MSW Concentration level
Designing Social Work Research, MSW level
Agency Management & Leadership Practice, MSW level

Fall, 2010:
Human Diversity, MSW level
Human Behavior and the Social Environment, MSW level
Field Seminar, MSW Concentration level

Adjunct Instructor, Virginia Commonwealth University, School of Social Work
Fall, 2009:
Person in Society III, BSW level
Spring, 2009:
Research for Clinical Social Work Practice II, MSW level

www.manaraa.com

Social Work Practice II, BSW level
Social Welfare Policy, Community Planning and Organization Practice II
Foundations of Research in Social Work Practice, MSW level
MSW & BSW Field Liaison
Fall 2008:
Research for Clinical Social Work Practice I, MSW level
Social Work Practice I, BSW level
Social Welfare Policy, Community Planning and Organization Practice
MSW & BSW Field Liaison
Spring 2008:
Research for Planning & Administrative Practice II, MSW level
Strategies for Social Work Planning & Administrative Practice, MSW Level
Social Work Practice II, BSW level
Foundations of Social Work Research I
MSW & BSW Field Liaison
Fall 2007:
Research for Planning & Administrative Practice I, MSW level
Social Work Practice I, BSW level
MSW & BSW Field Liaison
Summer 2007:
Foundations of Research in Social Work Practice, MSW level
Summer 2007, Social Work Practice: Fundamentals BSW level
Spring 2007:
Foundations of Research in Social Work Practice, MSW level
Spring 2007, Social Work Practice: Fundamentals BSW level
Spring 2007, MSW & BSW Field Liaison
Spring 2006:
Social Work and Oppressed Groups, BSW level
Spring 2006, Foundations of Research in Social Work Practice, MSW level
Spring 2006, Field Liaison, MSW & BSW Students
Fall 2005:
Social Work and Social Justice, MSW level
Fall 2005, Social Welfare Legislation and Service, BSW level
Spring 2005:
Social Work and Oppressed Groups, BSW level
Spring 2005, Foundations of Research in Social Work Practice, MSW level
Fall 2004:
Social Work and Oppressed Groups, BSW level
Social Work and Social Justice, MSW level

Mentoring/Advising experience

Dissertation Peer Reviewer 2009-2011

www.manaraa.com

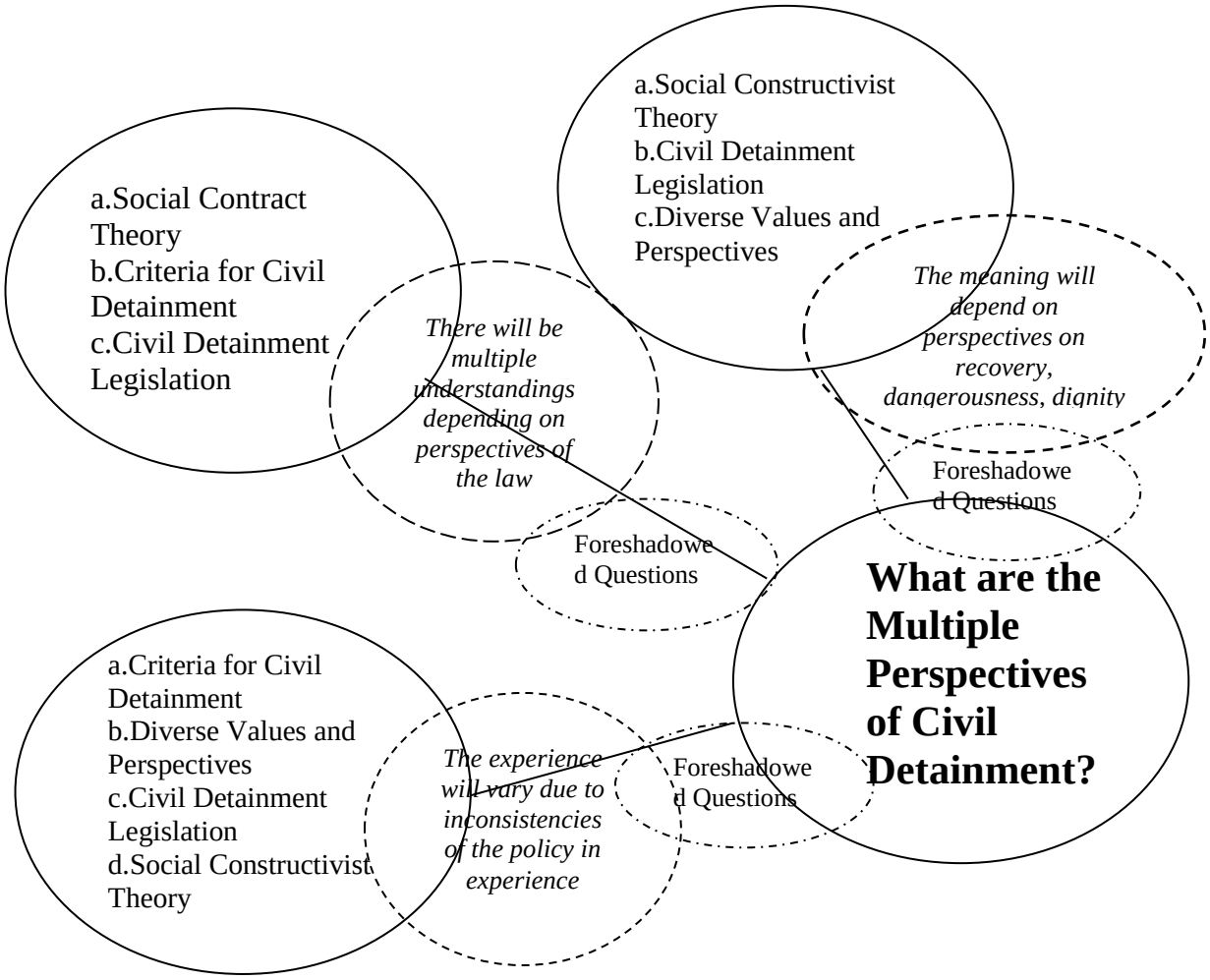
Jessica Jagger, MSW, Fulbright Student Fellow, PhD Candidate Virginia Commonwealth University School of Social Work
Dissertation Auditor 2009-2012
Abigail Kauffman Wyche, MSW, PhD Candidate VCU School of Social Work
Dissertation Auditor 2009-2012
Linda Love, MSW, PhD Candidate VCU School of Social Work

Awards

Baccalaureate Social Work Student Association, Virginia Commonwealth University Most Inspirational Educator Award May, 2008
Virginia Commonwealth University School of Social Work Leadership Award May, 2007
Virginia Commonwealth University Leadership and Service Who's Who Among Students Award May, 2006
Virginia Commonwealth University School of Social Work Elaine Rothenburg Award May, 2006
Virginia Commonwealth University nomination for the K. Patricia Cross Future Leaders Awards December, 2005
Virginia Commonwealth University School of Social Work Leadership Award May, 2005
Virginia Commonwealth University School of Social Work Leadership Award May, 2002
Honor Society of Phi Kappa Phi Virginia Commonwealth University School of Social Work May, 2002
memberships
NATIONAL ORGANIZATIONS
The Honor Society of Phi Kappa Phi April 2002 - Present
Council on Social Work Education September 2004 – Present
Society for Social Work and Research November 2002 – Present
Medical Library Association February 2006 – 2008
Society for Spirituality and Social Work November 2003 - 2007
REGIONAL/LOCAL ORGANIZATIONS
Massachusetts
Elder Justice Network September 2011 – Present
Virginia
Central Virginia Task Force on Domestic Violence in Later Life August 2001 – July 2010
VCU Qualitative Interest Research Group January 2006 – July 2010
VCU Domestic Violence Work Group August 2005 – July 2010
YWCA Transitional Housing Task Force February 2010 – August 2010

www.manaraa.com

Appendix K



www.manaraa.com

List of Figures

www.manaraa.com

List of Tables

www.manaraa.com

Code Book

1.Stigma
TEXP/I/I5/fam2rr/36-42; TEXP/I/I5/ind1art/93-94; TEXP/I/I5/ind4rom/118-120

2. Johnny
TEXP/I/I10/a/mh2hos/21-23; TEXP/I/I10/a/fr2nic/5-8; HR/D/D3/mh5el/84

3. Waste of resources
TEXP/I/I10/a/ fr4qu/72-29; TEXP/I/I10/a/mh2hos/21-23; TEXP/I/I11/a/fr4sn/81-83; TEXP/I/I8/mh5el/42

4. CIT/sensitivity training
INF/G/G3/fr2nic/1-25; INF/G/G3/fr3jer/26-35; INF/G/G3/fr41u/36-41; INF/G/G3/fr4sn/42-56

5. Confusion as to what is happening
TEXP/I/I9/fam2rr/1-10; HR/D/D3/fam4sam/38-40; HR/D/D3/fam4fr/14-37; HR/D/D3/fam4cc/1-14; HR/D/D3/fr3jer/50; HR/D/D3/mh1a/52-60; HR/D/D3/mh2hos/61-72; HR/D/D3/mh4dia/74-83

6 Before the illness
INF/I/I10/fam2rr/1; INF/I/I10/fam4cc/2; INF/I/I10/fam4fr/3-10; INF/I/I10/fam4fam/11-13; INF/I/I10/ind3brid/14; INF/I/I10/ind3jes/15-16; INF/I/I10/ind4alb/17-19; INF/I/I10/ind4rom/20; INF/I/I10/mh3dh/21-23

7 ER and bad perceptions
EMO/C/C2/fam4cc/5; EMO/C/C2/ind2brid/14-16; EMO/C/C2/ind3jes/17-19; EMO/C/C2/mh5el/31-32; LL/K4/fr3jer/34-35; EMO/I/I11/A/fr4ch/63-64; EMO/I/I11/A/mh5el/208-215

8 ER having higher priorities.
TEXP/I/I10/mn2hos/115; TEXP/I/I10/mh5el/11-121; LL/K4/ind3jes/36-37; HR/L/K2/mh5el/111-123

9 Trying to find help.
TEXP/I/I9/ind4alb/18-19; TEXP/I/I9/ind4rom/20-23; INF/J/J12/B/fam1sar/1-7; INF/J/J12/B/fam4cc/8-26; INF/J/J12/B/mh1a/81-90; INF/J/J12/B/fam4fr/27-41; INF/J/J12/B/fam4sam/42-44; INF/J/J12/B/fr1jo/45-48; INF/J/J12/B/fr3jer/49-53; INF/J/J12/B/fr4ch/54; INF/J/J12/B/fr4qu/55-60; INF/J/J12/B/fr4sn/61-68; INF/J/J12/B/ind2brid/69-73; INF/J/J12/B/ind3jes/74-75; INF/J/J12/B/ind4alb/76-80; INF/J/J12/B/mh1a/81-90; INF/J/J12/B/mh2hos/91; INF/J/J12/B/mh3dh/92-104; INF/J/J12/B/mh4dhum/105-109; INF/J/J12/B/mh4dia/110-120; INF/J/J12/B/mh4el/121-133

10 Money to be made

www.manaraa.com

TEXP/I/I11/a/fr1jo/26-29, 31; H/fr1jo/1-3

11 No beds
HR/fr1jo/ 45-49; HR/mh5el/213-223; LL/O2/mh4el/132-136

12 Laughing at mental illness/dehumanizing
TEXP/I/I10/fam2rr/8, 15-17, 22-24; TEXP/I/I10/fr4ch/61; TEXP/I/I10/ind4rom/110-111, 114; TEXP/I/I8/fam4fr/18-20; INF/I/I8/fam1sar/1-7; INF/I/I8/fam2rr/8-9; INF/I/I8/fam3bal/10-17; INF/I/I8/fam4fr/18-20; INF/I/I8/fr3jer/21-22; INF/I/I8/fr4sn/23-25; INF/I/I8/ind2brid/26-30;in3jes/31-34; INF/I/I8/ind4alb/35-36; INF/I/I8/ind4eth/37; INF/I/I8/ind4rom/38-40; INF/I/I8/mh3dh/41; INF/I/I8/mh5el/42

13 quote
fam2rr/70-72/74-75

14 Danger
TEXP/I/I11/a/mh5el/211-217;TEXP/I/I11/a/fr4sn/70-75; LL/O2/mh1a/118-119; LL/O2/mh4dhup/128; EMO/F/mh1a/110-112; EMO/F/mh2hos/113-116; EMO/I/I11/A/fr4sn/70-88

15 Experience on unit and lack of autonomy
TEXP/I/I10/fr4sn/64-66; HR/A/A5/fam1sar/1-2; HR/A/A5/fam2rr/3-5; HR/A/A5/fam4cc/6-7; EMO/I/I11/A/mh3dh/155-185; EMO/I/I11/A/mh5el/216-225; HR/A/A4/fam1sar/1-14; HR/L/L4/ind4art/42-45; HR/L/L4/ind2brid/42-57; HR/L/L4/ind3jes/58-63; HR/L/L4/ind4eth/74-78; HR/L/L4/ind4rom/79; HR/L/L4/mh4hos/80-82; HR/L/L4/mh3dh/83-97; HR/L/L4/mh5el/98-113

16 Speed of hearings
TEXP/I/I11/a/fr3jer/55-56; EMO/I/I11/A/fr2nic/40-44

17 Hearings
TEXP/I/I11/a/fr1jo/28-30, 32; TEXP/I/I3/fr1jo/1-4; TEXP/I/I3/ind4eth/244-247; HR/j1har/93-102; LL/O2/fr1jo/13-19; EMO/I/I11/B/fr1jo/1-9; INF/I/I11/B/fr1jo/1-9; INF/I/I11/B/fr3jer/10-12; INF/I/I11/B/fr4qu/13-17

18 Ethics
TEXP/I/I7/j1har/65-78; TEXP/I/I11/a/fr4sn/84-100, 106-110; TEXP/I/I11/a/fr4qu/65-69; TEXP/I/I11/a/fr1jo/24-25; TEXP/I/I11/a/mh5el/210; TEXP/I/I11/a/mh3dh/282-286; HR/j1har/103-104, 110-112; HR/mh2hos/128-135; HR/mh3dh/136-180; EMO/I/I11/A/mh4dia/194-198

19 Conflicting demands
TEXP/I/I11/b/fr1jo/1-9; TEXP/I/I11/b/fr3jer/10-11, 15-16; TEXP/I/I11/b/fr4sn/18-22; TEXP/I/I11/b/mh4dhup/27-32; TEXP/I/I11/b/mh4dia/33-43; TEXP/I/I11/b/mh4el/47-49; HR/j1har/123-125; TEXP/I/I11/a/fr2nic/40-41; INF/fr1jo/1-3; INF/mh3dh/4-5

www.manaraa.com

20 Scared/something wrong
TEXP/fam4cc/4-6; TEXP/I/I5/fam1sar/23-24

21 Loss of friends
TEXP/I/I11/a/mh4dia/125-126

22 The beginning
TEXP/I/I11/a/fam4fr/99-102; TEXP/I/I11/a/fam4fr/60-65, 71-72; TEXP/I/I9/fam4sam/11-13; TEXP/I/I9/ind2brid/14; TEXP/i/I9/ind3jes/15-16; TEXP/I/I9/ind4alb/17; INF/I/I2/fam1sar/1-13; INF/I/I2/fam3bal/14-15; INF/I/I2/ind1art/16-20; INF/I/I2/ind3jes/21-28; INF/I/I2/ind4alb/29-32; INF/I/I2/ind4rom/33-34; INF/I/I2/mh4dia/35-36; INF/I/I2/fam1sar/37-40; INF/I/I2/fam2rr/41-48; INF/I/I2/fam3bal/49-50; INF/I/I2/fam4cc/51-80; INF/I/I2/fam4fr/81-113; INF/I/I1/FR2NIC/114-120; INF/I/I2/fr3jer/121-124; INF/I/I2/fr4ch/125-137; INF/I/I2/fr4qu/138-143; INF/I/I2/fr4sn/144-151; INF/I/I2/ind1art/152-155; IND/I/I2/ind2brid/156-159; INF/I/I2/ind3jes/160-165; INF/I/I2/ind4alb/166-170; IND/I/I2/ind4eth/171-174; IND/I/I2/ind4rom/175-181; IND/I/I2/j1har/182-188; IND/I/I2/mh1a/189; IND/I/I2/190-205; IND/I/I2/mh3dh/206-207; IND/I/I2/mh4dia/208-218; IND/I/I2/mh4el/219-233

23 Unsure of the problem
TEXP/I/I11/a/fam4cc/60-88; LL/O2/fam4fr/1-12; TEXP/I/I11/a/fam4fr/96-98; TEXP/I/I11/a/fr4sn/85-87; TEXP/I/I11/a/fam4fr/55-57

24 Refusing services/not understanding illness
TEXP/I/I11/a/ind1art/88-92

25 Paranoia, escalation
TEXP/I/I10/ind4eth/103-107; HR/L/L4/ind4alb/64-73

26 Therapists wanting TDO but not getting it
TEXP/I/I11/a/mh1a/111-129; TEXP/I/I11/a/mh2hos/134-145; TEXP/I/I11/a/mh3dh/155-161; TEXP/I/I5/mh2hos/121-124; TEXP/I/I11/a/201-202; TEXP/I/I11/a/fr1jo/14-18, 36-37; TEXP/I/I11/a/fr3jer/61-62;TEXP/I/I11/a/mh2hos/130-133, 146-148, 152-154; TEXP/I/I11/a/179-180; HR/mh4el/184-201; LL/K4/fam1sar/1-16; LL/K4/mh4dhup/42-45; EMO/I/I11/A/mh1a/110-129; EMO/I/I11/A/mh2hos/130-154; EMO/I/I11/A/mh4dia/187-193; EMO/I/I11/A/mh5el/201-207

27 Perception of mental health services/developing a plan/getting a psychiatrist
TEXP/I/I11/a/mh4dia/190-193; HR/mh4el/224-231; EMO/I/I11/A/mh4dhup/186; INF/H/H1/fam1sar/1-16; INF/H/H1/fam2rr/17-21; INF/H/H1/fam3bal/22-29;INF/H/H1/fam4cc 30-36; INF/H/H1/fam4cc/37-73; INF/H/H1/fr1jo/74-102; INF/H/H1/fr2nic/103-125; INF/H/H1/fr3jer/126-149; INF/H/H1/fr4ch/150; INF/H/H1/fr4qu/151-187; INF/H/H1/fr4sn/188-189; INF/H/H1/ind2brid/190-192; INF/H/H1/ind3jes/193-196; INF/H/H1/ind4abl/197-210; INF/H/H1/ind4eth/211-213; INF/H/H1/ind4rom/214-220; INF/H/H1/j1har/221-230; INF/H/H1/mh1a/231-247; INF/H/H1/mh2hos/248-270; INF/H/H1/ mh3dh/271-280; INF/H/H1/mh4dia/281-288; INF/H/H1/mh4el/289-208

www.manaraa.com

28 Escalation, the illness
LL/K4/ind4eth/39; LL/K4/fam4cc/23-26; TEXP/I/I7/fr4ch/20-22; LL/K3/ind4alb/104; TEXP/I/I2/fam1sar/1-4; TEXP/I/I2/fam3bal13-14; TEXP/I/I7/fam3bal/15-44; TEXP/I/I7/fam4fr/45-77; TEXP/I/I7/fr2nic/78-84; TEXP/I/I7/fr3jer/85-88; TEXP/I/I7/fr4ch/89-101; TEXP/I/I7/fr4qu/102-107; TEXP/I/I7/fr4sn/108-115; TEXP/I/I7/ind1art/116-123; TEXP/I/I7/ind3jes/124-129; TEXP/I/I7/ind4alb/130-134; TEXP/I/I7/ind4eth/135-138; TEXP/I/I7/ind4rom/139-145; TEXP/I/I7/j1hr/146-169; TEXP/I/I7/MH3DH/170-171; TEXP/I/I7/mh4dia/172-182; TEXP/I/I7/mh5el/183-197; TEXP/I/I7/fam2rr/5-12; TEXP/I/I3/fam1sar/1-12; TEXP/I/I3/fam4cc/32-49; TEXP/I/I3/fam4fr/58-78; TEXP/I/I3/fr3jer/116-131; TEXP/I/I3/fr4ch/131-134; TEXP/I/I3/fr4qu/144-147; TEXP/I/I3/ind2brid/197-200; EMO/I/I11/A/mh4dia/199-200; INF/I/I3/fam1sar/1-17; INF/I/I3/fam2rr/18-25; INF/I/I3/fam3bal/26-31; INF/I/I3/fam4cc/32-49; INF/I/I3/fam4fr/50-81; INF/I/I3/fam4sam/82-87;INF/I/I3/fr1jo/88-91; INF/I/I3/fr2nic/91-97; INF/I/I3/fr3jer/98-131; INF/I/I3/fr4ch/132-137; INF/I/I3/fr4qu/138-164; INF/I/I3/ fr4sn/165-178; INF/I/I3/ind1art/179-196; HR/I/I3/ind2brid/197-208; HR/I/I3/ind3jes/209-219; HR/I/I3/ind4alb/220-229; HR/I/I3/ind4eth/230-251; HR/I/I3/ind4rom/252-263; HR/I/I3/j1har/264-281; HR/I/I3/mh3dh/282-288; HR/I/I3/mh4dia/289-295

29 Family's fear
TEXP/I/I7/ind4eth/61; EMO/F/fam1sar/1-19;EMO/F/fam4cc/25-40; EMO/F/fam4fr/41-60; EMO/F/fam4sam/61-65

30 Police deciding for a prescreening
LL/K3/fr4sn/93-94; LL/K3/fr4ch/59-60, 62, 63-65; LL/K3/fr3jer/52; LL/K3/fam4fr/1; EMO/I/I11/B/fr4qu/13-17

31 Fear of the police and evaluation
LL/K3/fam3bal/27-30; TEXP/I/I11/a/fr4sn/77-80; EMO/F/fam2rr/20-24;INF/G/G2/fam2rr/1-12; INF/G/G2/fam4cc/13-18; INF/G/G2/fam4fr/19-34; INF/G/G2/ fr1jo/35-38; INF/G/G2/fr2nic/39-46; INF/G/G2/fr3jer/47; INF/G/G2/fr4ch/48-54; INF/G/G2/fr4sn/55-71; INF/G/G2/ind2brid/72; INF/G/G2/ind4rom/73; INF/G/G2/mh1a/74-77;INF/G/G2/mh2hos/78-87; INF/G/G2/mh4dia/90-100; INF/G/G2/mh3dh/88-90; INF/G/G2/mh5el/101-104

32 Quote and fear of police and there trying to figure him out
ind6rom/10-12; LL/K3/fam1sar/1-6; LL/K3/fr2nic/43-44; TEXP/I/I8/fr2rr/21-22; TEXP/I/I8/fr4sn/23-25

33 Quote/police say yes, goes quickly
fam1sar/162-163; TEXP/I/I7/fam1sar/4-6;

34 Quote/going to jail
fam1sara/ 15/95-104;hr/d/d2/1sara/105-106

35 Telling family/him in handcuffs

www.manaraa.com

TEXP/I/I10/fam2rr/8; TEXP/I/I10/fam1sar/1-3; TEXP/I/I10/fam4cc/43-46; TEXP/I/I5/fam1sar/1-20; TEXP/I/I5/fam2rr/25-28; HR/L/K2/fam1sar/1-8; HR/L/K2/fam2rr/9-12; HR/L/K2/fam3bal/13; HR/L/K2/fam4cc/14-16; HR/L/K2/fam4fr/27-29; HR/L/K2/fam4sam/30-35; HR/L/K2/fr1jo/36-41; HR/L/K2/fr2nic/42-44; HR/L/K2/fr2jer/45-48; HR/L/K2/fr4qu/49; HR/L/K2/fr4sn/50-56; HR/L/K2/ind1art/57-58; HR/L/K2/ind2brid/59-64; HR/L/K2/ind3jes/65-68; HR/L/K2/ind4alb/69-70; HR/L/K2/ind4/eth/71-74; HR/L/K2/ind4rom/75-86; HR/L/K2/j1har/87-85; HR/L/K2/mh2hos/97-98

36 Waiting for csb to decide, trying to get help
LL/K4/fam1sar/5-8; HR/A/A2/fam1sar/1-23; HR/A/A2/fam4cc/24-26; HR/A/A2/fam4fr/27-42; HR/A/A2/fam4sam/43-45; HR/A/A2/fr2nic/46; HR/A/A2/fr3jer/47-48; HR/A/A2/fr4ch/49-55; HR/A/A2/ind1art/56-61; HR/A/A2/ind2brid/62-64; HR/A/A2/ind3jes/65-120; HR/A/A2/ind4alb/121-128; HR/A/A2/ind4eth/129-133; HR/A/A2/ind4rom/124-142; HR/A/A2/mh1a/143-144; HR/A/A2/mh2hos/145-149; HR/A/A2/mh3dh/150-151;HR/A/A2/mh4dhup/152-154; HR/A/A2/mh4dia/155-162; HR/A/A2/mh5el/163-178

37 Denied TDO
HR/fr1jo/1; HR/ind4alb/2-3; HR/mh2hos/4-8; HR/mh4dh/9-10; LL/O2/fr1jo/20-29

38 Quote-least restrictive
fr4qu/116; LL/K3/fam4fr/7-9; LL/K3/fam4fr/4-5

39 Quote-don't always get right information
j1har/108-109; LL/K3/fr2nic/37-39; LL/O2/fr2nic/37-39; EMO/I/I11/A/fr1jo/7-25

40 Jail scary
LL/K4/fam4fr/31-33

41 Family stunned and unsure what to do
LL/k3/119/mh1a/119; LL/K3/mh1a/118-119; LL/K3/mh1a/121-123; LL/k3/mh1a/129; TEXP/I/I6/fam1sar/7; INF/I/I11/fam1sar/1-47; INF/I/I11/fam2rr/48-52; INF/I/I11/fam3bal/53-56; INF/I/I11/fam4cc/5-91; INF/I/I11/fam4fr/92-121; INF/I/I1/fam4sam/122-124; INF/I/I11/A/fr4sn/125-131; INF/I/I11/mh1a/132-137; INF/I/I11/mh3dh/138-140; INF/I/I11/mh4dia/141-142

42 Lack of resources for rural
TEXP/I/I6/mh4dia/34-37; EMO/I/I11/A/fr1jo/-6; INF/I/I11/A/fr1jo/1-4

45 No insurance/cost of meds
HR/L/K2/mh5el104-110

43 Donna suicide and family/child intervention
LL/K3/mh4dhup/128; TEXP/ fam4fr/18-20

44 History of illness/stigma family

www.manaraa.com

TEXP/I/I10/a/fr4sn/3-4; TEXP/I/I11/39-47; TEXP/I/I11/fam2rr/50-51; TEXP/I/I11/fam3bal/53-55; TEXP/I/I11/fam4cc/88-91; TEXP/I/I11/fam4fr/92-95, 118-121; INF/I/I1fam1sar/1-13; INF/I/I1/fam3bal/14-15; INF/I/I1/ind1art/16-20; INF/I/I1/ind3jes/21-28; IND/I/I1/ind4alb/29-32; IND/I/I1/ind4rom/33; IND/I/I1/mh4dia/35-36; INF/I/I10/fam1sar/1-7; INF/I/I10/fam2rr/8-42; INF/I/I10/fam4cc/43-48; INF/I/I10/fam4fr/49-60; INF/I/I10/fr4ch/61-63; INF/I/I10/fr4sn/64-84; INF/I/I10/ind2brid/85; INF/I/I10/ind3jes/86-100; INF/I/I10/ind4alb/101-102; IND/I/I10/ind4eth/103-108; IND/I/I10/ind4rom/109-114; IND/I/I10/mh2hos/115-118; IND/I/I10/mh4el/119-121

45 No insurance
TEXP/fam4cc/13-15

46 In system there is help/dignity
TEXP/K/K3; IND/3jes/22-23; INF/I/I10/A/fr2nic/1-2; INF/I/I10/A/fr4sn/3-17; INF/I/I10/A/mh1a/18-19; INF/I/I10/A/mh2hos/20; INF/I/I10/A/mh4el/21-23

47 Resources and making a plan
TEXP/I/I7/fr4ch/12-19

48 Grateful for mental health
INF/I/I1/ind1art/40-42; INF/I/I4/ind3jes/1-2; IND/I/I6/ind4eth/32

49 Small community helping each other/dignity
LL/K3/mh1a/123-125; LL/K3/mh3dh/127; HR/L/K5/fr2nic/1-2; HR/L/K5/fr3jer/3-7; HR/L/K5/fr4ch/8-16; HR/L/K5/fr4qu/17-26; HR/L/K5/fr4sn/27-31; HR/L/K5/mh5el/32-39

50 Cop talking in mental health words/CIT
INF/G/G3/fr4sn/121-122; LL/O2/fam4fr/17-18

51 Medication difficulties
LL/K3/fam4fr/4-5

52 HIPPA/ Privacy Stigma and loss of friends
TEXP/I/I11/fam1sar/1-10; TEXP/I/I11/fam1sar/17-19, 23-35; EMO/C/C2/mh3dh/27-30; LL/K4/mh3dh/40-41

53 Loss of children/impact of mh on life
ind3jes/35-37; LL/K3/ind3jes/95-97; LL/K3/fr4sn/80-86; LL/K3/ind4rom/107; TEXP/I/I10/ind3jes/86-94; TEXP/I/I5/ind1art/96; TEXP/I/I5/ind3jes/97-103

54 Feeling bad about self humiliated
TEXP/I/I10/fam11sar/5-7; HR/L/K5/a/fr2nic/1; HR/L/K5/a/fr3jer/2-5; HR/L/K5/a/fr1qu/6; HR/L/K5/a/fr4sn/7-8; HR/L/K5/a/mh4el/9-12

55 Impact on client/Fear

www.manaraa.com

TEXP/I/I3/ind2brid/203-208; TEXP/I/I3/ind4eth/234-243;EMO/F/ind2brid/89-96; EMO/F/ind2jes/97-102; EMO/I/I11/fam4sam/122-124; EMO/ind2brid/141-151; EMO/ind3jes/152-205; EMO/ind4alb/206-207; HR/A/A1/ind4eth/11-12

56 Questions and nosiness
TEXP/fam1sar/1; TEXP/I/I10/ind3jes/95-100; LL/K4/ind4eth/39; HR/L/K4/fam4cc/1-4; HR/L/K4/fr4qu/5; HR/L/K4/fr4sn/6-9; HR/L/K4/ind4brid/10-12; HR/L/K4/ind4alb/4; HR/L/K4/ind4eth/14-15; HR/L/K4/mh3dh/18-21; HR/L/K4/mh4dia/22; HR/L/K4/mh5el

57 Hippa and the look
TEXP/I/I10/fam2rr 15-21, 33-42; TEXP/I/I9/fam1sar/1-6; HR/L/K3/ind4rom/1; HR/L/K3/mh4dia/2-3

58 Relationship killer
LL/K3/fr4qu/76-79; LL/k3/fr4sn/81-85; LL/k4/fr3jer/34-35

59 Strong to survive detainment/loneliness
TEXP/o/o2/ind4alb/2; LL/k4/fam3bal/17-18; TEXP/I/I8/fam2rr/8-9; TEXP/I/I8/fam3bal/10-17; TEXP/I/I8/ind2brid/26-30; TEXP/I/I8/ind2brid/26-30; TEXP/I/I8/ind3jes/31-34; TEXP/I/I8/ind4alb/35-36;TEXP/I/I8/ind4eth/37

60 She was more than a chart
LL/k3/fr2nic/41-42; LL/k3/fr4sn/87; LL/K4/fam4cc/22; TEXP/I/I10/a/fr4sn/9-17; TEXP/I/I10/a/mh1a/18-19

61 Feeling bad about self in process
INF/I/I7/ind2brid/26-27; LL/K4/fam1sar/9-12; TEXP/ind2brid/27; TEXP/ind3jes/31; TEXP/ind4eth/35-38; TEXP/I/I10/fr4sn/81-84; TEXP/I/I10/ind2brid/85; TEXP/I/I10/ind3jes/86-87; LL/K3/fr4sn/87; LL/O2/ind3jes/95-97

62 Police, you complied
LL/k3/mh5el/135-136; LL/k3/fam4fr/4-5; TEXP/I/I11/a/fr3jer/57-58; TEXP/I/I8/mh3dh/41; TEXP/I/I8/ind4rom/38; EMO/C/C2/fam4fr/4-10

63 Experience of detainment-being betrayed
HR/KI2/99-103; emo/ /;mh/3dih/7-23; LL/K4/ind3jes/36-37; LL/K4/ind4alb/38; LL/K4/mh4dhup/42-45; TEXP/I/I4/ fr2nic/1-2; INF/G/mh3dh/1-2; HR/fr4sn/87-90; HRL/K2/mh3dh/99-103; HR/L/L4/fam4cc/23-34

64 Rights at the hearing
TEXP/I/I11/a/mh4dia/187-189,194-198, 220; TEXP/I/I6/ind4eth/37; HR/fr1jo/1-28; HR/fr2jer/57-62; HR/fr4ch/74-76; HR/fr1qu/77-86; HR/ind4alb/91-92; HR/L/L1/fr3jer/3-37; HR/L/L1/fr4qu/18-20; HR/L/L1/ind3brid/21; HR/L/L1/ind4eth/22; HR/L/L1/mh3dh/26-33; HR/L/L1/mh4dia/34-35; HR/L/L1/mh5el/35-44

www.manaraa.com

65 Told about rights but not get them
ind4alb/92-95; EMO/I/I11/A/fr1jo/26-39; HR/A/A4/fam2rr/13-18; HR/L/L4/fam3bal/19-22; HR/L/L4/fam4sam/35-41; HR/A/A1/ind1art/1-6; HR/A/A1/ind2brid/5-6; HR/A/A1/ind4eth/11-12; HR/A/A1/ind4rom/13; HR/A/A1/mh1a/14

66 Taking time to understand
TEXP/I/I7/fr4ch/12; TEXP/I/I7/fr4ch/23; TEXP/I/I7/fr1jo/11

67 Congressman/standardizing/Positive changes
LL/O2/j1hr/101-117; LL/O2/mh2hos/118-120; LL/O2/mh3dh/121-124; LL/O2/mh4dia/125-139; LL/O2/mh4el/140-147; TEXP/fam1sar/1-2; TEXP/fam4fr/16-17; TEXP/I/I3/j1har/254-281; TEXP/I/I11/a/mh3dh/287-288, 292; EMO/I/I11/B/fr3jer/10-12; EMO/I/I11/B/fr1jo/1-9; EMO/I/I11/B/fr4sn/18-22; EMO/I/I11/B/j1har/23; EMO/I/I11/B/mh4dhup/27-32; EMO/I/I11/B/mh4dia/33-46; EMO/I/I11/B/mh5el/47-49; EMO/I/I11/A/fr3jer/48-62; EMO/I/II/A/j1har/89-110; INF/I/I11/B/fr1jo/1-9; INF/I/I11/B/fr4qu/13-17; INF/I/I11/B/fr4sn/18-22; INF/I/I11/B/j1har/23; INF/I/I11/B/mh1a/24-25; INF/I/I11/B/mh3dh/26; INF/I/I11/B/mh4hup/27-32; INF/I/I1/B/mh4dia/33-46; INF/I/I11/B/mh5el/47-49

68 Tx plan that had lack of resources
LL/k3/ind3jes/100-103; LL/O2/fam3bal/9-12; LL/K4/fam4cc/19-21; TEXP/I/I10/fr4sn/67-75

69 Quote allowing them to decline
TEXP/I/Ii6/fr1jo/132-135; TEXP/K/K1/fr1jo/132-135; EMO/C/C1/fam4fr/37-48

70 Person dependent
INF/J/J12a/mh4dia/118-122; LL/K3/mh1a/118-125; LL/K3/mh4dia/129-131; LL/K3/mh3dh/126-127; TEXP/I/I11/a/mh3dih/170-178; LL/O2/mh4dia/129-131

71 Trauma to the professional
LL/k3/fr2nic/45-46; TEXP/I/I10/a/mh2hos/20

72 Needs
LL/o2/fr1jo/19-36; LL/O2/fr2nic/39-46; LL/O2/fr4ch/50; LL/O2/fr4sn/63-71; LL/O2/ind4alb/72-79, 91-100; LL/K3/mh5el/131-136; TEXP/I/I11/a/fr1jo/10-13; TEXP/I/I11/a/fr3jer/48-49; TEXP/I/I11/a/fr2nic/46; TEXPI/I11/a/mh2hos/150-151; EMO/C/C1/mh4dia/150-162; LL/K4/fam4cc/19-30; LL/O2/fr1jo/29-36; LL/O2/fr2nic/40-50; LL/O2/fr3jer/51-56; EMO/F/j1har/103-109

73 Alternative services
TEXP/K/k7/fr4qu/129-136; INF/I/I7/fr4qu/129-136; EMO/I/I11/A/fr4qu/65-69

74 Monitoring Donna and her autonomy
TEXP/I/I7/fam1sar/1-3; TEP/I/I7/FAM3BAL/9; TEXP/I/I7/fam4fr/10; TEXP/I/I7/fr4ch/24-28; TEXP/I/I7/fr4qu/29-39; TEXP/I/I7/fr4sn/40-50; TEXP/I/I7/ind3jes/51-60;

www.manaraa.com

TEXP/I/I7/ind4eth/61; TEXP/I/I7/IND4ROM/62-64; TEXP/I/I7/mh1a/79 TEXP/I/I7/mh4dia/79-85; TEXP/I/I5/ind3jes/104-110; TEXP/I/I5/ind4alb/117; LL/O2/mh3dh/126-127

75 Impact on professional
TEXP/I/I11/a/mh3dh/162-169, 181-185; TEXP/I/I11/a/fr1jo/7-8; TEXP/I/I11/a/mh3dh/181-183; LL/K4/fam4bal/17-18; EMO/F/fr1jo/66; EMO/F/fr2nic/67-68; EMO/F/fr3jer/69-72; EMO/F/fr4qu/74-81; EMO/F/fr4sn/82-88; EMO/I/I11/fr4sn/125-131; EMO/I/I11/mh3dh/138-140; EMO/I/I11/mh4dia/141-142; EMO/I/II/mh1a/132-137; EMO/I/II/fr4sn/125-131; EMO/fr4sn/134-140; EMO/j1har/208-214; EMO/mh1a/215-220; EMO/mh2hos/221-224; EMO/mh3dh/225-254; EMO/mh4dia/255-257; EMO/mh5el/258-170

76 Death
TEXP/I/I11/fam1sar/10-13; TEXP/I/I7/fr4qu/148-162; TEXP/I/I3/fr4ch/135-137; TEXP/I/I3/fr4qu/148-162

77 Impact on family
TEXP/I/I11/fam4cc/3; TEXP/I/I7/j1har/66-71; TEXP/I/I5/fam4fr/69-70; EMO/I/I11/fam1sar/1-47; EMO/I/I11/fam2rr/48-52; EMO/I/I11/fam3bal/53-56; EMO/I/I11/fam4cc/57-91; EMO/I/I11/fam4fr//92-121; EMO/fam1sar/1-33; EMO/fam2rr/34-51; EMO/fam4cc/52-68; EMO/fam4fr/69-100; EMO/fam4sam/101-108; EMO/fr1jo/109-116; EMO/fr2nic/117-118; EMO/fr3jer/119-124; EMO/fr4ch/125; EMO/fr4qu/126-133;

78 Without help of state/ negative feelings
TEXP/I/I1/ind3jes/21-28; TEXP/I/I1/ind4alb/29-32; TEXP/I/I1/fam1sar/5-9; TEXP/I/I5/68; EMO/C/C2/fam1sar/1-4; INF/I/I11/A/fr1jo/5-39; INF/I/I11/A/fr2nic/40-47; INF/I/I11/A/fr3jer/48-62; INF/I/I11/A/fr4ch/ 63-64; INF/I/I11/A/fr4qu/65-69; INF/I/I11/A/fr4sn/70-88; INF/I/I11/A/j1har/89-110; INF/I/I11/A/mh1a/111-129; INF/I/I11/A/mh2hos/130-154; INF/I/I11/A/mh3dh/155-185; INF/I/I11/A/mh4dhup/186; INF/I/I11/A/mh4dia/187-200; INF/I/I11/A/mh5el/201-225; INF/I/I3/fam1sar/1-24; INF/I/I3/fam2rr/25-42; INF/I/I3/fam3bal/43-46; INF/I/I3/fam4cc/47-59; INF/I/I3/fam4fr/60-72; INF/I/I3/fam2rr/25-42; INF/I/I3/fam3bal/43-46; INF/I/I3/fam4cc/47-59; INF/I/I3/fam4fr/60-72;INF/I/I3/fr1jo/73-74; INF/I/I3/fr2nic/75-76; INF/I/I3/fr4ch/77-81; INF/I/I3/fr4sn/82-87; INF/I/I3/ind1art/88-92

79 Human kindness/ humanism
EMO/C/C1/ind4rom/62; TEXP/I/I7/fam3bal/9-10; EMO/C/C1/fam1sar/1-11; EMO/C/C1/fam3bal/12-14; EMO/C/C1/fam4cc/15-36; EMO/C/C1/fam4sam/49; EMO/C/C1/fr4sn/86-94; EMO/I/I11/B/mh3dh/26; INF/I/I7/fam1sar/1-3; INF/I/I7/fam2rr/4-6; INF/I/I7/fam3bal/7-9; INF/I/I7/fam4fr/10; INF/I/I7/fr1jo/11; INF/I/I7/fr4ch/12-28; INF/I/I7/fr4qu/29-39; INF/I/I7/fr4sn/40-50; INF/I/I7/ind3jes/51-54; INF/I/I7/ind4alb/55-60; INF/I/I7/ind4eth/61; INF/I/I7/ind4rom/62-64; INF/I/I7/j1har/65-78; INF/I/I7/mh1a/79; INF/I/I7/mh4dia/80-83; INF/I/I7/mh4el/84-85

80 Family history and family getting help

www.manaraa.com

TEXP/I/I1/fam3bal/14-15; TEXP/I/I1/ind1art/17-20; TEXP/I/I11/ind3jes31-34; TEXP/I/I6/fam4cc/9-19; TEXP/I/I6/fam4fr/20-15; TEXP/I/I6/ind3jes/27-30; TEXP/I/I6/fam3bal/2-8; TEXP/I/I6/ind4rom/33; TEXP/I/I6/fam1sar/1; INF/I/I6/fam3bal/2-8; INF/I/I6/fam1sar/1; INF/I/I6/fam4cc/9-19; INF/I/I6/fam4fr/20-25; INF/I/I6/ind2brid/26; INF/I/I6/ind3jes/27-30; IND/I/I6/ind4alb/31; IND/I/I6/ind4rom/33; IND/I/I6/mh4dia/34-37

81 Quote serves no purpose to blame
INF/l/l6/fam4fr/212-215

82 Ignorance about mh/not cognizant of illness/issues
TEXP/I/I10/fam2rr/8-21, 25-42; TEXP/I/I10/fam4cc/48; TEXP/I/I10/fam4fr/40-60; TEXP/I/I10/fr4sn/64-66, 76-80; TEXP/I/I10/ind2brid/85; HR/D/D2/fam1sar/1-17; HR/D/D2/fam2rr/18-22; HR/D/D2/fam3bal/23-26; HR/D/D2/fam4cc/27-38; HR/D/D2/fam2fr/39-41; HR/D/D2/fr4ch/42-45; HR/D/D2/fr4sn/46-49;HR/D/D2/ind1art/50-57; HR/D/D2/ind3brid/58-63; HR/D/D2/ind3jes/64-66; HR/D/D2/ind4alb/67; HR/D/D2/ind4eth/68-78; HR/D/D2/ind4rom/79-87; HR/D/D2/mh1a/88-91; HR/D/D2/mh2hos/92-94; HR/D/D2/mh3dh/95-102; HR/D/D2/mh4dhup/103-106; HR/D/D2/mh4dia/107-108; HR/D/D2/mh5el/109-111

83 Recovery
LL/O2/ind4rom/85-90; LL/O2/fam4fr/14-18; LL/O2/fam3bal/13; TEXP/I/I1/fam1sar/1-4; TEXP/I/I7/fam3bal/7-8; TEXP/I/I7/j1har/73-78; TEXP/I/I6/ind4eth/32; TEXP/I/I3/ind1art/194-196; TEXP/I/I3/ind3jesx/315-216, 226-227; TEXP/I/I3/ind4rom/255-259; TEXP/I/I3/ind4rom/252-254; EMO/C/C1/ind1art/95-96; EMO/C/C1/ind3brid/97-103; EMO/C/C1/ind4rom/120-133; LL/O2/ind4alb/98-104; LL/O2/ind4eth/105-106; LL/O2/ind4rom/107; LL/O2/mh2hos/120-125; EMO/I/I11/B/fr3jer/10-12; EMO/I/I11/B/mh1a/24-25

84 Tazer and police action
TEXP/I/I3/fam4cc/60-71

85 Reforms, advocacy, what is needed
LL/O2/fam1sar/1-8; LL/O2/fr3jer/47-49; LL/K3/fr4sn/80; LL/K3/j1har/108-117; LL/K3/fam4fr/2-3; LL/K4/fam1sar/13-16, 7-8; LL/K3/fam4fr/10-12; LL/K3/fr1jo/15-19; LL/K3/fr2nic/7-36, 40-42; LL/K3/fr3jer/53-54; LL/K3/fr4ch/61, 66-71; LL/K3/fr4sn/88-94; LL/O2/fr4qu/72-79; LL/O2/fr4sn/80-94; LL/O2/j1har/108/117; EMO/I/I11/A/fr2nic/45-47; HR/A/A3/fam1sar/1-5; HR/A/A3/fam2rr/5-12, HR/A/A3/fam4cc/13-20; HR/A/A3/fam4fr/21-24; HR/A/A3/fam4sam/25-28; HR/A/A3/ind3art/29-33; HR/A/A3/ind2brid/34-35; HR/A/A3/ind3jes/36; HR/A/A3/ind4alb/37; HR/A/A3/ind4eth/38-41; HR/A/A3/ind4rom/42-48; HR/A/A3/mh2hos/49-50; HR/A/A3/mh3dh/51-54; HR/A/A3/mh4dia/55-58; HR/A/A3/mh5el/59-60

86 Rights being met
LL/K3/fr1jo/13-14; LL/K3/fr2nic/45-50; LL/K3/fr3jer/51; LL/K3/fr3jer/55-56; LL/K3/ind4eth/105-106; LL/K3/fam4fr/6; TEXP/I/I4/1-2; EMO/C/C1/fam1sar/1-11;

www.manaraa.com

EMO/C/C1/fam3bal/12-14; EMO/C/C1/fam4cc/15-36; LL/K4/fam4fr/31-33; LL/K4/ind4alb/38; HR/L/L1/fam4cc/1; HR/L/L1/fam4fr/2; HR/L/L1/mh2hos/23-25; HR/L/fr1qu/1

87 Quote, good care
TEXP/K/K5/fam4cc/138-142; EMO/C/C1/fr1qu/78-85; EMO/C/C1/ind4alb/104-109; EMO/C/C1/ind4eth/110-110; EMO/C/C1/mh1a/134-137; EMO/C/C1/mh4dup/149

88 Taking time to understand
TEXP/I/I10/a/1-2; HR/D/D1/fam1sar/1; HR/D/D1/fam2bal/2-3; HR/D/D1/ind3art/8-12; HR/D/D1/ind3jes/13-15; HR/D/D1/ind4eth/15-17; HR/D/D1/ind4rom/18-22; HR/D/D1/mh2hos/23-24; HR/D/D1/fam4cc/4-7; EMO/C/C1/fr4ch/55-71; EMO/C/C1/fam4sam/49; EMO/C/C1/fr1jo/50-51; EMO/C/C1/fr2nic/52-53; EMO/C/C1/fr3jer/54; EMO/C/C1/mh2hos/138; EMO/C/C1/mh3dh/130-148; EMO/C/C1/mh4el/183-190; LL/O2/fr4ch/51-71; HR/D/D3/fam4cc/1-13

89 Tough love
TEXP/fam4cc/11-12; TEXP/ind2brid/29-30; TEXP/I/I5/mh4dia/125-126

90 Angry, why me?
EMO/B/fam1sar/1-14; EMO/B/fam2rr/15-27; EMO/B/fam4cc/28; EMO/B/fam4fr/29-40; EMO/B/fam4sam/41-46; EMO/B/fr1jo/47-53; EMO/B/fr3jr/54-55; EMO/B/ind2brid/56-58; EMO/B/ind3jes/59-62; EMO/B/ind4alb/63-64; EMO/B/mh1a/65-67; EMO/B/mh3dh/68-76; EMO/B/mh4dia/77-79

www.manaraa.com