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Exploring Decision-Making Experiences of Social Workers Completing Involuntary Commitment First Evaluations for Inpatient Psychiatric Treatment

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Walden University

College of Social and Behavioral Health

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Jesse Creech

has been found to be complete and satisfactory in all respects,
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Walden University

2025

Abstract

Exploring Decision-Making Experiences of Social Workers Completing Involuntary
Commitment First Evaluations for Inpatient Psychiatric Treatment

by

Jesse Creech

MSW, East Carolina University, 2011

BA, East Carolina University, 2008

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Social Work

Walden University

February 2026

Abstract

An increasing focus on the recovery, rights, and autonomy of individuals with serious mental illnesses has led to ongoing debate regarding the practice and legal regulation of involuntary commitment (IVC). To ensure ethical and appropriate patient care throughout this complex process, more knowledge is needed about social workers' decision-making process regarding the use of IVC. The purpose of this study was to investigate the decision-making processes associated with IVC for inpatient psychiatric treatment in North Carolina using the biomedical ethics framework. More specifically, the study addressed how licensed social workers describe their experiences and decision-making processes when determining whether to place clients under IVC while balancing legal and ethical responsibilities. Data were collected via interviews with 12 licensed clinical social workers who had worked for at least 1 year as a first evaluator for IVC placements. Thematic analysis revealed six themes: (a) holistic assessments within ethical boundaries; (b) ethics code, patient respect, and safety as main determinants of decision making; (c) knowledge of the patient and assessment of risk and protective factors as facilitators of decision making; (d) protection of patient autonomy balanced against risk of imminent harm; (e) beneficence and nonmaleficence are central principles in decision making; and (f) more training for magistrates, more clarity in policy, and more choice in facilities were recommended. The study may promote positive social change by educating future social workers about some of the challenges and associated best practices concerning IVC decisions. Other implications for positive social change include informing relevant social policy and future legislative actions.

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Dedication

This project is dedicated to my parents, who, both in their own ways, motivated me to advocate for those who struggle and are often overlooked by society. They guided me on the path of the social work profession.

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I would like to thank my amazing faculty advisors, Dr. Savas Georgiades and Dr. Kristin Richards. Without you, the completion of this project would not have been possible; I will be forever grateful for your tutelage, guidance, and support. I thank God for getting me to this point in my life and career. I would also like to thank my wife for her unwavering support throughout this journey, especially in the beginning when I came to her out of nowhere and said I wanted to return to school for my doctorate as we were discussing having our first child. Last, but not least, I would like to thank my littles, Addison and JJ. Without knowing it, you motivate me to continue growing and striving to always be the very best version of myself.

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Section 1: Foundation of the Study and Literature Review

There is considerable research on involuntary commitment (IVC; Hedman et al., 2016; Lee & Cohen, 2021; Morris, 2020); however, the perspectives of social workers as first evaluators are lacking in the available literature. I addressed the knowledge gap by investigating the perspectives of social workers in North Carolina. The study may promote positive social change by educating future social workers about some of the challenges and associated best practices concerning IVC decisions. Other implications for positive social change include informing relevant social policy and future legislative actions.

Throughout this manuscript, “IVC” is used interchangeably with other terms in past literature, including civil commitment or compulsory commitment. Additionally, whenever the term *licensed clinical social worker* (LCSW) is used, it refers to an individual with a master’s degree in social work who has met the North Carolina requirements to obtain independent clinical licensure. I grounded this qualitative study in Beauchamp and Childress's (1994) biomedical ethics framework and the National Association of Social Workers (NASW, 2021) *Code of Ethics*, which set the standards and ethical guidelines for the social work profession. The NASW *Code of Ethics* also provided a starting point for understanding what guides social work practice when making treatment and ethical decisions. Using these concepts, I examined the decision-making process of social workers when faced with potential ethical dilemmas of advocating for an individual's self-determination and autonomy while also considering

individual and community safety (Kendall & Hugman, 2016; Shdaimah & O'Reilly, 2016; Walton & Hall, 2017).

In this section, I discuss the general research problem, the purpose of the study, and the knowledge gap in the current literature that I addressed. I also analyze the biomedical ethics framework and the social work code of ethics as they relate to my topic. In the literature review, I provide a historical context for IVC, a general and comparative outline of the commitment process, and an overview of national trends. The literature review concludes with the justification for reviewing social worker decision making during the IVC process through the lens of the biomedical ethics framework and the NASW (2021) *Code of Ethics*.

In Section 2, I describe the research design and rationale that I used as part of a broader qualitative approach. The section also includes exploration of the ethical considerations of the research process. In Section 3, I present the findings, including the techniques I used for data analysis and a summary of the results. Section 4 offers a conclusion that encompasses the study's potential application to social work ethics, recommendations for social work practice, and implications for social change.

Problem Statement

In this project, I examined the decision-making process of social workers conducting initial evaluations for IVC in North Carolina, with a focus on ensuring ethical and appropriate patient care throughout this complex process. In recent years, there has been a growing focus on the recovery, rights, and autonomy of individuals with serious mental illnesses, with ongoing debates regarding the practice and legal regulation of IVC;

criticism of IVC from the perspective of human rights; and consensus among different stakeholders, including social workers, on the need to support the rights of the patients, which has made ethical and appropriate patient care a topic of growing relevance (Abbott, 2021; Iudici et al., 2022; Morandi et al., 2021). The ability for social workers in North Carolina to become certified first evaluators was not fully granted until 2011, making it new to the profession (Senate Bill 437 [Public] General Assembly of North Carolina Session, 2011). This newness may contribute to why the decision-making process of social workers regarding placing someone under IVC has not been studied. The absence of a federal tracking system complicates the process of determining the need for IVC, including differences in the IVC process among states. Individual states determine the length of emergency holds, legal criteria, and who can complete IVC petitions and first evaluations (Lee & Cohen, 2021; Morris, 2020). Therefore, the scope of this research was specific to the state of North Carolina.

Significant bodies of research indicate that even without the added complexities of the IVC process, the decision-making process for clinicians is complex (Fistein et al., 2016; Wand & Wand, 2013). Multiple experts have underscored the need for more consistency in how other professionals, such as psychiatrists, interpret IVC criteria (e.g., Gordon, 2016; Kaufman & Way, 2010; Shdaimah & O'Reilly, 2016). The same has also been said for the decision-making process specific to clinical social workers (Christopher et al., 2021; McLaughlin et al., 2010; Smith, 2014).

Researchers have examined how social workers use their professional code of ethics in reaching general treatment decisions (Henwood, 2008; Scheyett et al., 2009;

Walt et al., 2022; Walton & Hall, 2017; Wu et al., 2013; Young, 2015); researchers have also investigated various parts of the IVC process separately, including reviewing criteria for commitments across states (Lee & Cohen, 2021), IVC impacts on emergency departments (Creed et al., 2018; Nok Lam et al., 2016; Nordstrom et al., 2019; Zeller et al., 2014), and significant controversy regarding IVCs within the mental health field (Nicolini et al., 2018). Additionally, there is ample research about the potential impacts of IVCs on the patients (Goldman, 2015; Jones, Gius, Shields, Collings, et al., 2021; Jones, Gius, Shields, Florence, et al., 2021). However, the decision-making process of social workers completing IVC first evaluations for inpatient psychiatric treatment had not been previously researched in North Carolina or on a national level.

Purpose Statement and Research Questions

In this qualitative study, I explored how licensed social workers describe their experiences and decision-making processes when determining whether to place clients under IVC while balancing legal and ethical responsibilities. I answered the following research questions (RQs):

- RQ1. What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment?
- RQ2. What ethical, legal, or administrative issues tend to compound this process?
- RQ3. What factors facilitate this decision-making process?

RQ4. What type of ethical conflicts surround this process and how are they resolved in the field?

1. What specific principles of biomedical ethics are present in the decision-making process? How do they affect the decision-making process?
2. What recommendations do social workers have for needed policy changes that will facilitate the IVC process?

Research about the decision-making process of social workers regarding petitions for IVC in North Carolina was lacking. Understanding how these clinicians described experiences and decisions to utilize IVC could be a key component in furthering education on the IVC process in the future.

Nature of the Doctoral Project

I used a qualitative design to explore and understand how licensed clinicians, specifically social workers in North Carolina, described their decision-making experiences with IVC for inpatient psychiatric care. The primary focus of qualitative research was to understand the meaning behind experiences and how they could be viewed, explored, and interpreted (Patton, 2015; Ravitch & Carl, 2021). Individual, semistructured interviews with clinical social workers in North Carolina were conducted to collect the necessary data. Once Walden University's Institutional Review Board (IRB) approval was granted, I recruited 10–12 LCSWs, certified as first evaluators, from a minimum of two different employment settings, to participate in face-to-face interviews, either in person or via Zoom. A first evaluator, also known as a “first examiner,” is an eligible psychologist, physician, or any mental health professional or health professional

certified (under North Carolina General Statutes 122C-263.1; General Assembly of North Carolina, 2018) to perform the first examination for IVC (North Carolina Department of Health and Human Services, 2024). LCSWs were among the professionals eligible to become the first evaluators.

Significance of the Study

I addressed a current knowledge gap by exploring the experiences of social workers in North Carolina during the decision-making process as they completed their first evaluations for IVCs. First evaluations by LCSWs remain relatively new in North Carolina and have not been empirically studied. However, the general decision-making process for social workers is complex and still heavily debated (McLaughlin et al., 2010). Exploring how social workers engage in decision making provides insight into avenues for improving social work practice in this field.

This study is significant because the results from investigating the stated gap can inform further research that may lead to updated policies, ensuring that IVCs are tailored to individual patients. Data from this study could aid in educating future social workers and first evaluators, ensuring a deeper understanding of the legal criteria for IVCs. This process may ensure appropriate use of these criteria, combined with ethical considerations, in the decision-making process. With IVCs being a legal process, court systems have received criticism for deferring to mental health professionals (Henwood, 2008). However, social workers stand out from other clinicians in their decision making due to their unique code of ethics (Walt et al., 2022; Walton & Hall, 2017; Young, 2015).

I examined how IVCs infringe on a client's rights and autonomy during the treatment process. When individuals facing mental health concerns desire treatment, policies should prioritize voluntary inpatient treatment over encouraging it (Substance Abuse and Mental Health Services Administration, 2019). Currently, first evaluators, also known as first examiners, bear the complicated role of determining if the client's presentation is severe enough to require them to be held against their will (Henwood, 2008).

In conclusion, the knowledge gained from this study may help enhance the ability of social workers and other professionals to make more informed and ethical decisions regarding IVC. As such, the findings may be of particular relevance to the field of social work, contributing to the ongoing debate on the conflict experienced by social workers who generally view coercion as a violation of fundamental rights while agreeing that it may be of benefit to the patients and unavoidable in the particular context of psychiatry (Abbott, 2021; Morandi et al., 2021). The findings may also help inform existing practices and policies, as the experiences and decision-making processes of licensed social workers may reveal ways to aid and enhance their decision making, as suggested by Morandi et al. (2021). This study may promote social justice at the individual level for patients who are at risk for IVC. In addition, their communities and society may benefit in turn, as these patients may be helped to become more productive and less stigmatized. They may learn to invest their talents in the betterment of not only themselves but also their communities and society.

Theoretical/Conceptual Framework

Biomedical ethics, along with its accompanying four-principle framework, was the primary approach to navigating, educating, and evaluating dilemmas and moral/ethical concerns in health care (Beauchamp & Childress, 1994, 2001, 2019; Ebbesen et al., 2012; Iserson, 1999; Page, 2012). The logical connections between this framework and the nature of this study included considering the intersections between ethics and the legal requirements for the IVC process. Additionally, clinicians may be compelled to balance perspectives on individual well-being and safety versus collective well-being and community safety. Understanding how clinicians navigated these intersections during the evaluation process was vital. Social workers strive to respect autonomy and self-determination, values that align with the care continuum, while IVCs, as a legal issue, align with the justice continuum.

Furthermore, social work and medicine draw on the same moral philosophy realm to develop professional ethics; a review of this view is a necessary and standard part of ethics education in both professions (Beauchamp & Childress, 2001). Although sharing a foundation, both forms of ethics have had to adjust in response to changes in social, cultural, and legal norms; medicine focuses more on ethics, while social work focuses more on values (Pugh, 2017). Beauchamp and Childress (1994) outlined the four primary principles within the biomedical ethics framework:

- respect for autonomy (respecting the decision-making abilities of individuals)
- nonmaleficence (avoiding the causation of harm)
- beneficence (providing benefits and balancing benefits, burdens, and risks)

- justice (fairness in the distribution of benefits and risks). (p. 1)

Notably, justice and beneficence were also mentioned as core values in the NASW (2021) *Code of Ethics*.

The social work profession has demonstrated widespread use of these principles, but with limited agreement on how to rank them in terms of importance (Page, 2012). However, Brazg et al. (2015) argued that, due to the profession's general gravitation toward a strength-based perspective and advocacy for justice, social workers linking with biomedical ethics could increase their understanding of patients' needs and achieve better patient outcomes. The authors also pointed out that, although the concept is referred to as biomedical ethics, it is not specific to the medical field. Beauchamp and Childress (1994) cited their principles as forming the core of common morality. Given the similarities of these four principles with the social work code of ethics, their application formed the conceptual framework of this study. The following sections discuss the principles and information about the rules of each one (Iserson, 1999).

Autonomy

The principle of autonomy holds that an individual with capacity and competency has made choices voluntarily after being effectively informed of all pertinent information. Iserson (1999) described the rules associated with autonomy as telling the truth, respecting privacy, protecting confidential information, obtaining consent, and helping others make decisions without influence or coercion. When viewing autonomy from a moral lens, a significant factor includes ensuring that someone is not deprived of their freedom. Respecting the autonomy of others also entails respecting an individual's

privacy and maintaining honesty (Ebbesen et al., 2012). Regarding IVC, the ethical dilemma of maintaining individual autonomy and community safety/benefit has long been a fundamental ethical challenge for mental health services (Zheng et al., 2019).

Nonmaleficence

The principle of nonmaleficence means do not harm (Beauchamp & Childress, 1994; Iserson, 1999). Rules encompassed within this principle include refraining from killing, causing pain or suffering, incapacitating, causing offense, and preventing life (Ebbesen et al., 2012; Iserson, 1999). However, there are some situations where doing harm can be considered justified and does not fall under the principle of nonmaleficence. A prime example is the use of lethal force in self-defense (Iserson, 1999). A common ethical dilemma under nonmaleficence is balancing therapeutic objectivity with the potentially negative consequences of said intervention (Zheng et al., 2019).

Justice

Iserson (1999) described justice and how benefits and burdens are distributed according to rules, including the assurance that each person either receives an equal share or is allocated according to their need, contribution, effort, or merit. Justice may also include not stealing, not punishing the innocent, ensuring the rights of others, and providing equal consideration under the law (Ebbesen et al., 2012). Zheng et al. (2019) stated that justice is considered one of the fundamental rights of man, and individuals with mental health struggles have their inherent right to receive equal treatment; however, psychiatric patients are not treated equally, as some view these patients as having lost their right to be treated as a valued person.

Beneficence

The principle of beneficence merely means bringing benefit to others (Iserson, 1999). Iserson (1999) pointed out that the principle of beneficence requires some action, whereas nonmaleficence can exist without action. The author also described the rules of beneficence as preventing harm, protecting or defending others, assisting in removing circumstances that cause harm, and helping those with disabilities or in danger. Other considerations for beneficence include helping those in danger and fostering the development of younger generations (Ebbesen et al., 2012). When considering IVC and beneficence, the dilemma includes considerations of whether being placed under commitment will harm the individual.

Rationale for the Blended Framework

Pugh (2017) argued that the NASW (2021) *Code of Ethics* is too specific in some areas but too vague in others, while containing principles and standards that sometimes contradict each other. Although this process provided the code of ethics with some flexibility, the author noted that some social workers also choose to avoid utilizing the code of ethics when faced with an ethical concern. In response to this, Pugh connected the field of social work to the principles of biomedical ethics, noting that the primary principles that carry the field of social work are the same as those in biomedical ethics: autonomy, beneficence, nonmaleficence, and justice.

Autonomy is a key concept in social work ethics and is sometimes referred to as self-determination. However, the two concepts have slight differences in that self-determination is often considered a component of autonomy (Pugh, 2017). Sasson (2000)

also argued that the ethical principles of beneficence and respect for autonomy present a conflict in decision making that is found throughout social work practice. Not only do these principles arise independently, but they also frequently conflict when what the individual wants for themselves is thought to be something that will cause harm. Consequently, the blended framework was used to uniquely contribute to understanding the decision-making processes of social workers, as social workers might experience a conflict between the general ethical principle that coercion as a violation of fundamental rights while agreeing, on both legal and moral ground, that it might be of benefit to the patients and unavoidable in the particular context of psychiatry (Abbott, 2021; Morandi et al., 2021).

Values and Ethics

The NASW (2021) *Code of Ethics* created the standards and ethical guidelines for the social work profession. A defining feature of social work is the profession's dual focus on individual well-being in a social context and the well-being of society (NASW, 2021), both of which may conflict in the IVC process. The NASW (2021) *Code of Ethics* also outlined the core values and ethical principles that comprise the social work profession: service, social justice, the dignity and worth of the person, the importance of human relationships, trustworthy actions, and competency maintenance. When considering a social worker's ethical responsibilities, the primary focus is respecting and promoting a client's self-determination, along with taking practical steps to protect the rights and interests of those clients who are deemed unable to make their own decisions.

This situation was related to the current problem when considering how IVC removed self-determination and autonomy from clients in a possibly unethical manner.

Another ethical concern in the realm of IVCs involves their legal nature. When considering the core value of social justice within the NASW (2021) *Code of Ethics*, one can reflect on the intersection of IVC and legal systems. Although much of the training clinicians in the mental health field receive is clinical, IVCs are firmly a legal matter that often involves courtroom aspects, within which the social workers are removed (Henwood, 2008). Appelbaum (1992) explained that the responsibility for civil commitment is a process shared between the criminal justice/legal system and the mental health system, implying that the process depends on successful and appropriate collaboration between the two. Although there is an opportunity for these systems to work in harmony, there may be situations where mental health professionals seek involuntary inpatient commitment for individuals who do not meet full legal criteria. Comparatively, situations can arise where the justice systems fail to ensure full legal criteria are met before an individual experiences IVC or allow petitions to be taken on individuals who are not mentally ill.

Many ethical crossroads are present for clinicians in the field of mental health. Most notable is the ambivalence toward practices, such as physical restraint and legal processes, which also serve as forms of treatment (Brodwin, 2014). Clinicians, particularly psychiatrists, are expected to be taught the importance of recognizing the power inequality between themselves and their patients and how this power impacts care points, such as informed consent (Brodwin, 2014). This project supported the values and

principles of the NASW (2021) *Code of Ethics* by highlighting areas in which the code was applied and could be applied to ensure social justice for committed individuals.

Review of the Professional and Academic Literature

A comprehensive search for scholarly, peer-reviewed articles and textbooks was conducted between 2000 and 2023 across PubMed, PsycArticles, Google Scholar, SocINDEX, APA PsycInfo, and MEDLINE. The keywords for the literature search included *qualitative, purposeful sampling, semistructured interview, thematic analysis, involuntary commitment OR hospitalization, social work, ethics, North Carolina, law, involuntary commitment, civil commitment, biomedical ethics, ethical dilemmas, moral reasoning, moral development, decision making, and clinician experience*. Additional articles were also found through citations from the journals that originated in this search.

Few studies in the United States have focused on social workers and the IVC process. Those that were found focused on social workers' views toward IVC, as opposed to social workers completing the steps within IVC (Henwood, 2008; Kendall & Hugman, 2016; Wu et al., 2013). However, much of this research was outside of the preferred 5-year time frame of this literature review. The available research on IVC appeared to focus on the psychiatric process, as opposed to social workers, and state differences in the IVC process, IVC impacts on those committed, or IVC in countries outside the United States. Based on these factors, sources older than 5 years were also used to support the present literature review.

Historical Overview of Involuntary Commitment

The basis of IVC can be traced back to early Roman and Greek laws that recommended the property of those perceived to have a mental illness to be seized for family and royalty while they were put away in another location (Garland, 2022). Garland (2022) discussed IVC in the United States, providing an extensive historical review that sheds light on various aspects. Initially, mental health concerns were not considered legal, and those suffering were removed from society and placed in institutions or facilities. For years, this process could be initiated by the family or anyone who felt the person would benefit from treatment. It was not until around the 20th century that individuals with mental health concerns started having protections written into law, partially due to wrongful commitment and the abuse and neglect that occurred in asylums in the previous century coming into light at higher rates.

Garland (2022) stated that although civil commitment initially came into legal play as a form of protection, it inevitably led to numerous problems, including prolonged confinement without appropriate treatment and confinement for individuals who did not necessarily require it. Despite some federal guidelines being in place to force states into assisting those with mental health concerns, many states misallocated this funding. They cut additional funding for inpatient programs, leading to deinstitutionalization and another shift in the laws surrounding IVC. This shift in the late 20th century saw commitment laws move away from the standard of an individual benefiting from treatment and toward the "dangerousness" standard (Garland, 2022, p. 1052). Garland (2022) further explained this standard as requiring convincing evidence that an individual

poses a danger to themselves or others to qualify for an IVC, as opposed to the previous standard, which only required showing that they would benefit from treatment. Although this shift did result in a loss of services for some who benefited from the treatment standard, it led to different interpretations of the standard ‘dangerousness’ by legal experts and mental health professionals (Garland, 2022).

Examining the intersection of criminal justice and IVCs, Stone (2016) noted that a criminal defendant often has more protection than someone facing involuntary civil commitment; freedom is at stake, along with the confinement potential. Borecky et al. (2019) outlined different challenges that psychiatrists face when considering IVC for suicidal patients and those with significant mental health concerns. The authors noted that the general standard of care for suicidal patients frequently involves an IVC, with society believing that it is the clinician's legal responsibility to protect the patient from suicide. Fistein et al. (2016) also noted that incarceration rates are not significantly lower in areas with strict legal criteria for IVC.

National Trends Regarding Involuntary Commitment

Despite the ethical, legal, clinical, and human rights concerns associated with IVC, no federal system in the United States currently tracks this (Lee & Cohen, 2021; Morris, 2020). Such a tracking system would be challenging to initiate and maintain at the federal level due to the varying laws and criteria for commitment across all 50 states (Lee & Cohen, 2021). Despite this lack of data, Lee and Cohen (2021) accumulated data from 25 different states and confirmed that the rates of commitment increased by three times the mean state population increase; however, they did not note data on those who

were originally petitioned but later had those petitions discontinued due to not fully meeting the criteria. There are significant differences among individual states regarding the definition of dangerousness when considering the commitment criteria of dangerousness to self or others. Some states require proof of an attempt or threat, and others only require the prediction of future dangerousness (Gordon, 2016).

Additionally, Hedman et al. (2016) examined all states and investigated the emergency hold process, where an individual is held to determine whether they meet the criteria for IVC. This situation is when a person is considered dangerous to self or others and is waiting for a first evaluation or similar process, depending on the state of residence, to determine if an IVC to inpatient treatment will occur. The authors found that the length of time an emergency hold could legally last significantly varies by state, with the shortest being 24 hr (including North Carolina), the longest being 10 days, and three states not specifying a time frame.

Individual states differed in who could initiate an emergency hold; some specified that it could only be initiated by police officers, trained mental health professionals, or judges. Additionally, 22 states permitted any individual to initiate an emergency hold, while another 22 states required judicial approval beforehand, with nine states requiring the judge's approval before admission. Regarding health care professionals or mental health professionals, the data did not specify what type. Therefore, it was unknown whether social workers in other states fell into these categories. Deciding who may initiate an emergency hold on an individual could result in different interpretations of whether a person constitutes a danger to themselves or others, as the criteria for

dangerousness may be interpreted differently by law enforcement, mental health professionals, and community members.

To further explore this situation, the Treatment Advocacy Center (2018) analyzed the laws concerning IVC across 50 states in the United States. The analysis revealed staggering results, showing that all states took different approaches to the commitment process. IVC to psychiatric treatment involves unique dilemmas not often found in other medical settings, leading to the need for special attention to be paid to patients' experiences arising from this potentially coercive treatment (Hui et al., 2020). Nationally, involuntary outpatient treatment used as an alternative to inpatient IVC varies. For instance, survey data indicated that 13 states and the District of Columbia commonly used the process, while in another 21 states, use was rare or very rare (Kisely et al., 2017).

Involuntary Commitment in North Carolina

In North Carolina, the criteria for IVC to an inpatient psychiatric treatment facility involve a mental illness diagnosis and being either dangerous to self or others in the relevant past (General Statutes [G.S.] 122C; General Assembly of North Carolina, 2018). According to G.S. 122C, any person is legally entitled to present a petition to a magistrate or clerk of the superior court for an affidavit for IVC, and the magistrate or clerk must have reasonable grounds to believe the information provided before issuing a custody order to law enforcement. Given the layperson's ability to initiate this process, it is unsurprising that there may be some misalignment between clinical and legal interpretations of the appropriate use and application of petitions and how those without

this specific training may interpret them. North Carolina also allows the IVC of an individual to substance use treatment or outpatient treatment. However, as these are not pertinent to this research, they will not be outlined. Additionally, once the IVC process begins, the parallel legal process also commences. The individual is referred to as a "respondent" instead of a patient within IVC law and paperwork.

While completing their analysis, the Treatment Advocacy Center (2018) noted that the North Carolina statute contained six complete sets of criteria by which an individual was assessed for dangerousness. The term *criteria* refers to the conditions that must be met under the statute to qualify for involuntary treatment. However, the verbiage in the statute was also considered, specifically the use of relevant past, which was never fully and precisely defined. After a petition is complete, an individual must undergo what is called the first examination to determine if the petition will be continued or discontinued, which occurs at either an emergency crisis center or a local hospital emergency department (General Assembly of North Carolina, 2018).

Knopf (2020) published an article for North Carolina Health News discussing North Carolina's lack of tracking for IVC data and the results from advocate data collection in each county. Limitations of this data set included its focus on petitions for IVC, which did not differentiate between those that were upheld and those that were discontinued. However, this data demonstrated that in Wake County alone, petitions for IVC increased from 5,411 in 2009 to 11,290 in 2008. In other similar-sized areas, such as Mecklenburg County, the increase was from 6,103 in 2009 to 14,328 in 2018. Although these numbers were staggering, it was interesting that other counties of similar sizes, such

as New Hanover, demonstrated an increase from 1,722 in 2009 to 3,792 in 2018. In total, it was discovered that forced psychiatric treatment under IVC increased by 91% over a decade, overtaking the state's population growth while paralleling national trends. Knopf also shared that the rate of IVC continues to climb.

In an independent report completed by the North Carolina Statewide Telepsychiatry Program-NC-STeP (Saeed, 2020), data for IVCs and discontinuations were tracked for hospitals within their network. Their East Carolina University-affiliated program has a network noted to contain 45 hospitals across the state of North Carolina utilizing telepsychiatry services. A portion of this report outlines the total number of IVCs in these facilities versus the number of IVCs overturned since the onset of tracking. Annual statistics within their network showed that 37% or more of IVCs were overturned each year between 2016 and 2019.

This overall lack of widespread official tracking in North Carolina leaves gaps in knowledge regarding the percentage of petitions for IVC that are appropriately used, especially considering the lack of tracking for petitions that were upheld versus those that were noted to be inappropriate and subsequently discontinued. Regarding the general capacity of a state to treat those struggling with mental health, a minimum of 50 beds per 100,000 people is considered necessary to deliver minimally satisfactory treatment; North Carolina aligns with every other state in its failure to meet this standard (Fuller et al., 2016). According to Fuller et al. (2016), North Carolina had 8.9 beds per 100,000 residents in 2016. Additionally, the number of beds in state hospitals, considered a last

resort for individuals with little to no other option for appropriate treatment, was fewer than 12 beds per 100,000 population in the United States, the lowest level on record.

Initially, North Carolina only allowed physicians and eligible psychiatrists to complete first evaluations for IVC. However, various professions are currently eligible to become trained and credentialed in this process by amending the legal statute to include physicians and eligible psychiatrists, as well as others. With the growing increase in community mental health needs around the early 2000s, it was found that the state was lacking in professionals who could conduct the initial examinations for IVC (Senate Bill 437 [Public] General Assembly of North Carolina Session, 2011). Due to this issue, in 2003, North Carolina legislation approved the initiation of a pilot project, which became official law in 2011, allowing LCSWs to receive training and complete the first examinations for IVC (Senate Bill 437 [Public] General Assembly of North Carolina Session, 2011). Despite this change, psychiatric bed shortages continue to impact the population in many areas; one of these areas for North Carolina is emergency departments, where a patient struggling with a mental health crisis can wait for days, even weeks, for a bed at a treatment facility.

Impacts of Limited Mental Health Care Systems on Emergency Departments

Local communities have felt the impact of gaps in the mental health care systems most, leaving many emergency departments overburdened with patients experiencing acute mental health crises (Creed et al., 2018; Nok Lam et al., 2016; Nordstrom et al., 2019; Zeller et al., 2014). Patients with mental health conditions are frequent users of emergency departments, and those who are homeless tend to use these departments as

their providers for primary care services while being more likely to return within 30 days of discharge (Nok Lam et al., 2016). These frequent emergency department visits can further strain an already exhausted system. The impacts on emergency departments are national, with these patients occupying more time than nonpsychiatric visits. This issue has resulted in increased inpatient admission and transfer, using a higher percentage of self-pay or charity care compared to non-psychiatric visits (Creed et al., 2018; Nordstrom et al., 2019).

Additionally, emergency departments are unequipped to provide psychiatric treatment at the same level as an inpatient psychiatric hospital. Hence, those who truly need treatment often wait several days for a bed at an appropriate facility (Nordstrom et al., 2019). Zeller et al. (2014) indicated that patients waiting for psychiatric beds could wait between 6.8 and 34 hr, surpassing wait times for those arriving with only physical needs. Additionally, long waits and limited resources in emergency departments often exacerbate patient symptoms (Zeller et al., 2014). This situation not only makes for a dangerous situation for staff and patients due to an increase in reported assaults but also causes concerns for medical patients who may be diverted from the emergency room due to issues of overcrowding (Vicario, 2012).

The costs associated with boarding these patients are often high, especially when an average of 52%–71% of patients receiving mental health evaluations are often admitted into the hospital for boarding (Vicario, 2012). North Carolina is not immune to these concerns. Between 1992 and 2011, North Carolina lost 1,879 psychiatric beds from state-operated facilities, while between 2008 and 2011, the number of patients presenting

to emergency departments with a primary mental health or substance use diagnosis increased by more than 38% compared to a 6% increase in the total number of emergency department visits for the population (Vicario, 2012). Also, in 2012, around 10% of visits to a North Carolina emergency department were due to a primary mental health diagnosis, not including substance use (Creed et al., 2018).

In a report focusing on the years 2008–2010, Hakenewerth et al. (2013) stated that 93% of reported emergency department visits were due to a mental health diagnosis, and 31% of patients with a mental health diagnosis required hospital admission, compared to 14% of total emergency department visits. This finding echoed Zeller et al.'s (2014) findings that patients with a mental health diagnosis are 2.5 times more likely to be admitted to the hospital following their emergency department visit. Some patients may continue to wait for an appropriate bed placement for a week or longer (Vicario, 2012).

Taking a more in-depth look at the first 6 months of 2010 in North Carolina, Akland and Akland (2010) noted that those in the emergency department for psychiatric placement waited an average of 63.1 hr, or approximately 2.6 days. Although this study focused on patients waiting for placement at state-run psychiatric facilities, the numbers reported by the authors remained staggering. Within this 6-month time frame, 3,339 individuals waited for admission to a state hospital, with 86% of these being in hospital emergency departments or crisis centers. The authors estimated that these wait times cost hospitals over \$7,000,000 due to the accommodation needs of mental health patients. Although some of these data could seem outdated, it was essential to remember that the General Assembly gave permanent approval, allowing LCSWs to complete the first

examinations for IVC as of October 1, 2011 (Senate Bill 437 [Public] General Assembly of North Carolina, Session 2011).

The wait times are primarily attributed to a lack of psychiatric beds in the community and the complicated requirements that sometimes come with seeking these beds (Zeller et al., 2014). However, the question arises as to how many of these patients genuinely require inpatient placement. Also questionable is whether those who are involuntarily committed truly meet the legal criteria for that commitment, as opposed to the commitment process being completed inappropriately (Creed et al., 2018).

The Debate About Involuntary Commitment in the Mental Health Field

IVC has remained a topic of significant controversy within the mental health field (Nicolini et al., 2018). The initial criterion for commitment was based solely on thoughts that individuals could benefit from or needed treatment. However, unknown to most, these laws have undergone significant changes (Garland, 2022; Gordon, 2016). Concerns persist that clinicians may recommend commitment for patients who do not fully meet the legal criteria solely because this clinician believes the patient may benefit from inpatient treatment (Appelbaum, 1992). This concern is further compounded by studies that demonstrate clinicians' limited understanding of commitment criteria, resulting in inconsistent interpretations and implementations of the standards required to meet the full criteria for IVC (Shdaimah & O'Reilly, 2016). Appelbaum (1992) made this observation over 3 decades ago, and multiple studies since have continued to demonstrate these concerns.

Aside from exploring the decision-making process for social workers regarding IVC, more needs to be known about the experiences and perceptions of health care professionals in general, as most studies have focused on psychiatrists and psychologists (Walt et al., 2022). Walt et al. (2022) studied clinicians' experiences with moral distress when deciding for or against IVC due to substance use. In doing so, the authors defined moral distress as the negative feeling when a clinician must pursue a treatment option against their moral judgment due to institutional constraints. The authors used a qualitative approach and noted that out of the 21 interviewed clinicians, only four were social workers, and 71% experienced moral distress when using IVC for substance use. Clinicians employed in emergency departments reported less distress than those working in outpatient practices. The authors also noted that clinicians across all interviewed professions expressed some moral distress due to the ties between the IVC process, law enforcement, and the criminal justice system.

Kaufman and Way (2010) studied 61 psychiatry residents from prominent universities who had attested to completing involuntary petitions in the past. The authors found that when presented with case studies, where the scenario did not meet the criteria, few residents chose not to complete IVCs. Additionally, the residents were tested on their knowledge of the commitment criteria and demonstrated limited knowledge despite stating that it was important for someone committed to meet them. A similar study reported that some psychiatrists interpreted dangerousness criteria as requiring an individual to pose an immediate, clear, or imminent danger to self or others. In contrast,

others thought the criteria required the individual's circumstance to present a probable, possible, or potential danger (Gordon, 2016).

On the opposite side of valuing autonomy and self-determination, Gordon (2016) argued on behalf of providers who feel that individuals should still be able to meet the criteria for commitment, even if they are not a danger to themselves. The author argued that mental health treatment and care are so difficult to access that an individual should meet the criteria for commitment if they are deemed unable to provide themselves with basic needs, such as food or shelter. J. B. Williams (2021) also argued that the criteria for IVC have become stricter in the past several years, making it more difficult for patients who would benefit from the process to receive treatment. J. B. Williams further implied that this issue has led to increased homelessness and incarceration for individuals with mental illness.

Henwood (2008) stated that mental health professionals, in general, are prone to struggle between the traditional view of an individual needing treatment and the individual's desire not to receive this treatment against their will. Further, Creed et al. (2018) discussed the issues of malingering in mental health patients, where they feign symptoms conducive to meeting IVC criteria for secondary gain, like food or shelter. Differentiating these malingered symptoms from factual ones can be challenging for even seasoned clinicians. Christopher et al. (2021) surveyed court clinicians who performed evaluations for civil commitment for substance use disorders in Massachusetts. The authors found that many considered a wide-ranging set of behaviors to establish imminent risk, and that many (more than half) reported having endorsed commitment on

one or more occasions without satisfying statutory criteria. Eight of the 32 clinicians surveyed were social workers. The authors noted that these findings confirm the need for better guidance on commitment and suggest the need for additional research.

Even patients who have experienced involuntary treatment hold views that vary, with Priebe (2019) noting that about 3 months after involuntary hospital treatment, 50% of patients felt that their IVC was needed. Other studies demonstrated that IVC could lead to feelings of confinement and diminished autonomy (Borecky et al., 2019). Clinicians generally tend to rate IVC as a more positive experience compared to committed patients. However, patients who are granted more autonomy and involvement in their commitment process view it as a needed process that aids in their recovery (Nicolini et al., 2018).

Considerations Pertaining to Involuntary Commitment for Social Work

There is limited research in this realm of social work regarding IVC in North Carolina, as the state's general assembly only provided permanent approval for LCSWs to train and be credentialed to provide first evaluations for IVCs in 2011 (Senate Bill 437 [Public] General Assembly of North Carolina Session, 2011). As suicide rates have continued to increase despite national prevention strategies (Cramer & Kapusta, 2017), clinical social workers are on the front lines assisting individuals who struggle with mental illness. Although social workers make up the largest population of providers to serve those with mental health concerns, hospital psychiatrists generally attend commitment hearings, leaving the voices of social workers absent in legal proceedings or large-scale events concerning IVC (Henwood, 2008).

Social Worker Decision Making

Questions regarding the decision-making process for clinicians, specifically social workers, have been pondered for many years, with research revealing a wide range of evidence on how the process unfolds (Christopher et al., 2021; McLaughlin et al., 2010; Smith, 2014). Previous research indicated that the decision-making process varies based on the topic of the decision (Smith, 2014). Additionally, the results indicated that social workers often struggle to provide their rationale for about a quarter of their decisions, even when specifically asked (Smith, 2014). Smith (2014) also suggested that social workers' actions, in these cases, do not always align with the conscious application of knowledge regarding the situation. Theorists have proposed numerous processes and factors that an individual requires for moral and ethical decision making, with perspective-taking and empathy being considered the most widely supported (Garrigan et al., 2018).

Taylor (2017) argued that social workers rarely used structured decision making, justifying their decisions more often based on their experiences, values, research, or client preferences. The author also noted that social workers often made judgments rather than decisions, as they frequently found themselves in roles where they were invited to make recommendations rather than take decisive action. However, with the IVC process, social workers make decisions, not recommendations. McLaughlin et al. (2010) researched decision making by practitioners at a nonprofit human services agency. The researchers also found that in making decisions, clinicians relied most on their values/beliefs, experiences, knowledge, and ability to empathize with their clients'

situations. The researchers also found that several clinicians reported relying solely on their instincts when making decisions.

Fenton (2015) reported that social workers experience less stress in decision making when they feel they can discuss the information with senior colleagues. Fistein et al. (2016) discussed how individual differences in how clinicians assess risk, as well as the role of gut instinct based on experience, as opposed to structured best practice methods, have been highlighted as factors affecting day-to-day mental health decision making. The authors employed qualitative methods to investigate the decision-making process and the role of individual differences in determining how clinicians, referred to as approved mental health professionals, assessed risk in England and Wales. These approved mental health professionals are nonmedical professionals from diverse backgrounds.

For the study, Fistein et al. (2016) discussed with five psychiatrists and conducted individual interviews with 15 psychiatrists and one approved mental health professional (the exact title was unspecified). After analysis, five themes emerged regarding the decision-making process: the individuals' diagnosis, availability of alternative treatments, potential response to treatment, risk assessment, and the individuals' capacity to make treatment decisions. An additional theme was the difficulty of decision making. Fistein et al. also discussed the role of individual differences in how clinicians assess risk and the impact of experiences as factors affecting day-to-day mental health decision making, rather than relying on structured best practice methods.

Principles of Biomedical Ethics, Social Work, and Involuntary Commitment

It is no secret that an individual's mental health can significantly impact their physical health, while in the United States specifically, having a mental health diagnosis has directly correlated with poor health outcomes and an increase in medically related financial strain (A. R. Williams, 2016). Although the field of biomedical ethics has traditionally detached itself from mental health, there are unavoidable ties that should be considered. A. R. Williams (2016) indicated that the field of biomedical ethics had missed opportunities to partner with the field of mental health to form a collaboration when navigating through some of the most challenging issues. These issues involve coercion, self-determination, autonomy, patient rights, provider authority, freedom of choice, and perspectives on the balance between individual rights and societal interests. Within social work practice, advocacy and justice are often described and used together when discussing human rights (Steen, 2018).

Wu et al. (2013) investigated the attitudes of psychiatric social workers regarding the IVC process, potential coercion, and human rights. The authors noted conflicts between the role of the psychiatric social worker as an advocate and their participation in the commitment process to protect the patient and society from harm potentially; this issue can be a source of distress for some social workers. Despite this issue, the study found that most social workers supported commitment and viewed it as a means of providing care.

When paralleling thoughts on seclusion and IVC, Zheng et al. (2019) used the four principles of the biomedical ethics framework to explore potential ethical issues

within each principle. Seclusion is like IVC, as both are justified on the grounds of safety. Both also raise concerns about additional harm to patients while arguably violating their rights. Findings suggest that although the clinical use of seclusion aims to reduce injury caused by aggressive and disruptive behavior, more attention should be paid to the adverse side effects. Zheng et al. (2019) argued that autonomy was not violated in these cases because the patients lacked capacity at the time due to their decision making. However, the principles of justice, beneficence, and nonmaleficence were violated in some ways. Essentially, seclusion could be seen as an intervention with good intent, sometimes resulting in negative consequences for patients, similar to the IVC process.

Due to the nature of IVCs, they can impact both the individual and society, underscoring the importance of a clinician's consideration of autonomy, nonmaleficence, beneficence, and justice. Determining if social workers understand these concepts related to the NASW (2021) *Code of Ethics* was also essential. There was also a connection between this framework and IVC in considering the values of autonomy/self-determination with beneficence, as a patient might lack insight and a desire for treatment while meeting legal criteria for IVC to inpatient psychiatric treatment. Kendall and Hugman (2016) also used this model to examine social workers' insight regarding the ethics of IVC, specifically for treating anorexia nervosa. Although the authors made the point that IVC for eating disorders is a unique situation, even when compared to IVC for mental health concerns, they discussed the decision-making context and how it may be relevant to professional ethics.

Another consequence of general IVC is the potential for individuals to form untrusting relationships with providers, be less likely to disclose suicidal ideation in the future, and be more likely to encourage others to avoid psychiatric hospitalization, even when treatment may be warranted (Jones, Gius, Shields, Collings, et al., 2021). Youth and young adults view treatment through this route as more punitive than therapeutic and note it as a predominantly negative experience due to the requirements for law enforcement involvement (Jones, Gius, Shields, Collings, et al., 2021; Jones, Gius, Shields, Florence, et al., 2021). Individuals who experience police involvement in the IVC process are also more likely to view the process as a criminalized one instead of an avenue for treatment, which can further contribute to the individual feeling distressed and morally or ethically inferior (Jones, Gius, Shields, Collings, et al., 2021).

Another risk at the individual level for those subjected to an inappropriate petition for IVC is the struggle with self-autonomy and self-determination, given the removal of personal decision making involved in this process (Shdaimah & O'Reilly, 2016). IVCs do not promote a recovery perspective, and treatment that is considered coercive, such as IVC, can negatively influence treatment outcomes and future pursuits of therapeutic intervention (Shdaimah & O'Reilly, 2016). Individuals can also develop negative views toward mental health providers and treatment in general (Shdaimah & O'Reilly, 2016), damaging these relationships. Silva et al. (2021) also discussed that admitted patients involuntarily demonstrate little clinical improvement and mixed bearings on suicidality. Additionally, including dangerousness in the commitment criteria has increased the

stigma toward those with mental illness by increasing the public perception that those who struggle with mental health issues are violent (Gordon, 2016).

Summary

The pillar of decision-making dilemmas about involuntary psychiatric treatment is power conflicts. Research has suggested that shifting involuntary treatment models to be more person and family-centered requires attention to how that power is used (Hui et al., 2020). Existing research on forced treatment has yielded interesting results. Kisely et al. (2017) found that individuals on any form of involuntary treatment were no less likely to be readmitted than participants in the control groups, whether on entirely voluntary treatment or subject to erratic supervised treatment.

While marking the 40th anniversary of the principles of biomedical ethics, Beauchamp and Childress (2019) noted that these principles continue to guide professional practice, especially in complex situations, where moral principles conflict with moral considerations and social responsibilities. This discussion can relate directly to IVCs when considering if the moral principle of autonomy for an individual is overridden, in a particular situation, by moral considerations of safety for the individual or society. Beauchamp and Childress discussed that considering these principles could be most beneficial in situations that present as ambiguous, cause uncertainty, or result in moral conflict.

As North Carolina and many other states continue to use correctional facilities and hospital emergency departments to treat those struggling with mental illness due to a significant deficit in psychiatric beds (Fuller et al., 2016), taking a closer look at IVCs for

inpatient psychiatric treatment becomes vital. Given the numerous layers involved in IVC, initiating the decision-making process for social workers may pave the way for additional studies in this field.

Section 2: Research Design and Data Collection

Introduction

A debate has stood the test of time regarding the fundamental nature of social work knowledge and its decision-making process (Christopher et al., 2021; McLaughlin et al., 2010). Many clinical decisions in mental health treatment involve weighing patient autonomy against risks of harm to the patients and the community. In contrast, patients have reported that decision making and autonomy regarding their care were important to them and their treatment outcomes (Hui et al., 2020; Liang et al., 2022).

I used a qualitative methodology. Conducting individual semistructured interviews, I employed purposeful sampling to select participants for this study, including only those participants who were LCSWs in North Carolina, had completed the certification process to become a first evaluator for IVC, and had at least one experience of making such a decision. These criteria helped ensure that the participants were qualified to answer the RQs and could provide the information most relevant to the current research. For data analysis, a thematic analysis was conducted to explore how social workers experienced decision making during the initial evaluations for IVC treatment. This section, Section 2, discusses the research design, including the intended research approach and the rationale behind it. The methodology utilized in the study is also discussed, along with the participants and instrumentation. This section is followed by an overview of the data analysis process and the ethical procedures in place to protect the participants in this study.

Research Design

In this qualitative study, I examined how licensed social workers described their experiences and decisions regarding the placement of clients under IVC, while balancing legal and ethical responsibilities. The phenomenon of interest for this study was the experiences of clinicians during the decision-making process when deciding whether to place an individual under an IVC for inpatient psychiatric treatment. The purpose of this study was aligned with the qualitative approach and methodology, as the study sought to explore how licensed social workers described their experiences and decision-making processes when determining whether to place clients under IVC while balancing legal and ethical responsibilities. Understanding the complexities of this process is crucial because it involves significant ethical, professional, and personal considerations for clinicians. Therefore, qualitative methods can be especially suited to exploring these types of issues in social work and human services (Darlington & Scott, 2020).

In this study, I answered the following RQs:

- RQ1. What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment?
- RQ2. What ethical, legal, or administrative issues tend to compound this process?
- RQ3. What factors facilitate this decision-making process?
- RQ4. What type of ethical conflicts surround this process and how are they resolved in the field?

RQ5. What specific principles of biomedical ethics are present in the decision-making process? How do they affect the decision-making process?

RQ6. What recommendations do social workers have for needed policy changes that will facilitate the IVC process?

To answer the RQs, I employed a basic qualitative design. According to Patton (2015), the primary goal of the basic qualitative approach is to explore or describe experiences to gain a more in-depth understanding of the meaning applied to our daily experiences. A basic qualitative design offers a robust and flexible approach when the research aims to delve into individuals' subjective experiences and perceptions (Alam & Asmawi, 2024), making it well-suited for this study on clinicians' experiences and decision-making processes for IVC to inpatient psychiatric treatment. This qualitative methodology enabled me to capture the depth and complexity of participant experiences (Alam & Asmawi, 2024), particularly in the context of IVC evaluations, providing valuable insights into the factors that influence clinicians' decisions.

The basic qualitative design was aligned with these research goals by focusing on the subjective experiences and interpretations of clinicians. Furthermore, researchers can use basic qualitative studies to address important inquiries without being confined to a specific tradition within a single design (Alam & Asmawi, 2024; Patton, 2015). This flexibility was essential for this study because it aimed to understand the lived experiences of clinicians in making IVC decisions. This area can be influenced by many factors ranging from personal beliefs to professional guidelines and ethical considerations (Shobassy, 2021). The aim was to understand not only the decision-making process but

also the various contextual and individual factors that influenced these decisions. I used this approach to gain a comprehensive exploration of the clinicians' experiences by capturing the complexity and depth of their decision-making processes.

Although the research design was suitable for the present study due to its focus on the participants' lived experiences, it contained several limitations that needed to be addressed. First, my own bias might have influenced the study's findings (Ravitch & Carl, 2021). To address this limitation, I relied on member checking, during which the participants reviewed their responses, and reflexivity. This process involved keeping a reflective journal and reflecting on my personal reactions and emotions during the research process in relation to social judgments and beliefs. Another major limitation was the small sample size, which is typical of qualitative research methods (Hennink & Kaiser, 2022) and raises concerns about the generalizability of the research findings (McDermott, 2023). Although this limitation was necessary for this study due to its focus on the depth of respondent experiences and perceptions, I hoped that future studies would further serve to support the study findings and instill more confidence, at least partially, in the generalizability of these findings.

The previous literature review highlighted the need to identify potential factors that may influence clinicians' decision-making experiences. These factors may include institutional policies, personal beliefs and values, ethical considerations, and the specific circumstances of each case (Shobassy, 2021). The basic qualitative design was appropriate for exploring these multifaceted influences because it provided a framework for examining the rich, detailed, and nuanced experiences of those who worked in social

work and human services (Darlington & Scott, 2020), including clinicians involved in the IVC decision-making process.

Methodology

Participants

The group of interest for this study included LCSWs in North Carolina who had completed the certification process to become first evaluators for IVC and were employed in various agencies. Participants were recruited using multiple avenues, including contacting the North Carolina Chapter of the NASW (2021) via their listserv. The North Carolina Department of Health and Human Services also listed those who had received certification as first evaluators. Another avenue for recruiting participants for this study was to contact locations that served as initial evaluation sites in North Carolina. I obtained organizational approval from each evaluation site to determine if their supervisor would allow for the distribution of a study announcement and invitation. The approved organizational letter coming from the respective department head within the organization (see Appendix A) was presented and provided to the IRB.

I also utilized Facebook groups for North Carolina social workers as an additional avenue to advertise participation (see post in Appendix B). Ensuring participants were willing to participate without any added pressure was imperative. It was also essential to be aware that, with these potential referral sources, a participant might have been more hesitant to disclose experiences without assured confidentiality. Once identified, potential participants were contacted via email, wherein an official study invitation was presented. Additionally, I presented the informed consent form to the participant and provided them

with it. In any research study, protecting the security of the data and the privacy and confidentiality of human subjects is a central concern. In the context of this study, the focus on IVC made these decisions even more significant. Accordingly, signing an informed consent form to indicate voluntary and informed participation was required before any participant's participation was confirmed. Additionally, member checking was performed to ensure that participants' views were accurately reported. To protect privacy, all identifying markers were eliminated from the data. To identify the participants, alphanumeric identifiers were used. Any data or signed documents related to the research remained stored on a password-protected electronic device or in a locked file drawer. The information and data related to the study will be maintained for 3 years, after which they will be permanently destroyed.

I used the purposive sampling strategy to recruit participants. According to Andrade (2021), purposive sampling allows qualitative researchers to focus on selecting those participants who best address the RQ. Purposive sampling is frequently used in qualitative research to identify participants who are well-informed about the area of interest and are fully willing and able to participate in the study (Andrade, 2021; Palinkas et al., 2013). Purposive sampling ideally leads to cases rich in information, particularly when based on criterion sampling (Andrade, 2021; Benoot et al., 2016; Patton, 2015). This sampling strategy allowed me to select participants who met a prearranged set of criteria. In this study, LCSWs in North Carolina who had completed the certification process to become first evaluators for IVC and were employed in various agencies in the state were recruited. The primary inclusion criterion was the following: (a) must be an

LCSW in North Carolina who had completed the certification process to become a first evaluator for IVC and (b) must have at least one experience of making such a decision. Exclusion criteria included social workers who still needed to complete the certification process and those whose certification had expired. An additional exclusion was any other mental health professional certified to complete the first evaluations.

According to Braun and Clarke (2021), data saturation is the point at which no new themes or findings are yielded. Hennink and Kaiser (2022) conducted a review of empirically based studies and found that, for qualitative studies, saturation could be achieved with small sample sizes of nine to 17 interview participants. Jassim and Whitford (2014) found that interviews with 10 participants are sufficient to reach data saturation in qualitative research. Accordingly, the expected number of participants for this study was between 10 and 12, at which point data saturation was reached. I recognized that data saturation had been achieved when continued analysis of the data stopped yielding new themes, indicating that all primary variations of the phenomenon had been identified. Coding of transcripts and thematic analysis were used to determine the findings.

Prospective Data

The overall method of collecting the data was semistructured, one-on-one interviews. According to Kallio et al. (2016), interviews are the most widely used qualitative data method, with semistructured interviews used most often. Osborne and Grant-Smith (2021) also noted that semistructured interviews are flexible, as they can be conducted among both individuals and groups. Semistructured interviews also offer a

degree of reciprocity between the interviewer and participant while allowing the interviewer to improvise follow-up questions as needed (Osborne & Grant-Smith, 2021). According to Patton (2015), personal narratives gathered from interviews can yield an in-depth understanding of participants' complex, lived experiences.

I collected data by conducting semistructured interviews in person or on Zoom. I used open-ended questions, with the anticipation of also using appropriate probing for additional information as needed. First, the interview was set up, based on availability, once the participants had signed informed consent forms containing information about the study and the interview. At the start of the interview, participants again reviewed the informed consent form, which outlined the approximate length of the interview, its nature, purpose, and the recording method. They were also informed of their right to stop the interview at any time and to withdraw their participation from the study if they wished to do so, as well as of any risks associated with the study. They were given resources in case they felt emotionally vulnerable after the study, for example, when unpleasant memories were being provoked. Resources included a list of local mental health providers, along with walk-in behavioral health urgent care or crisis lines if they felt the need to contact someone immediately.

The expected length of each interview was approximately 60 min. I asked detailed follow-up questions for clarity, as needed. To conclude each interview, participants were asked if there was anything else they wanted to share or if they had any questions for me as the researcher. If there was none, I proceeded to thank the participant and give further knowledge about what to expect from me. Participants were allowed to request potential

resources if they needed to speak with a therapeutic professional. They were reminded of the transcription process and informed that they would receive a copy of the transcript for content verification once it was completed. They were invited to contact me by email or phone if needed and allowed to request the results of the data analysis. The participants were then again thanked for their time.

During the data collection process, analytic memos were also used to track thoughts and reflections on the data collection and instruments. For the individual interviews, the analytic memo was completed as the conversations were transcribed, reflecting the participants' thoughts and reactions, and then during a review of the completed transcript for coding. Analytic memos allowed me to track thoughts about the instruments, participants, phenomenon, and any important observations during the research process (Saldaña, 2021). According to Saldaña (2021), these analytic memos help identify ethical concerns or dilemmas, reflect on thoughts and feelings, code categories and themes, identify patterns, and identify problems or concerns. The analytic memos also allowed for notations of reactions and interactions, specifically with the participant in the individual interview.

Ethical issues of varying levels may arise in many types of studies, including qualitative ones (Sanada, 2021). Due to these issues, I considered how decisions could have influenced both the participants and the research process (Ravitch & Carl, 2021). Again, analytic memos were used to help me stay mindful of any concerns when completing the individual interviews and during the coding process.

Instrumentation

To collect the interview data, I followed an interview protocol that I developed (see Appendix C). The rationale for using this method and instrument was grounded in the need to explore a specific phenomenon—clinicians’ decision-making processes for IVC—within a unique context. Given that no existing studies had directly examined this particular phenomenon in this context, I developed the interview questions based on a review of the literature that explored decision making in related or alternative capacities.

The interview protocol was carefully developed to ensure that it would effectively capture the rich, detailed information needed for this study. The interview questions were designed to be open-ended, encouraging participants to share their experiences in depth. This approach aligned with the recommendations of Dunwoodie et al. (2023), who emphasized the importance of avoiding leading questions that might impose my expectations onto the participants. I aimed to gather authentic, unfiltered data by formulating questions that allowed participants to express their thoughts and experiences freely and openly.

I was an instrument in the interview process. Interviews can vary significantly depending on the interviewer's skill (Ravitch & Carl, 2021). Additionally, there was considerable importance in developing trust and rapport with each participant (Rubin & Rubin, 2012). I also kept in mind their positionality, as this process was an integral part of the study and could have influenced the research on all levels (Ravitch & Carl, 2021). To facilitate this situation, I made sure to ask detailed follow-up questions, encourage

conversation, and be aware of own stereotypes to prevent causing any harm to the study participants (Dunwoodie et al., 2023; Rubin & Rubin, 2012).

In an excellent qualitative interview, an interviewer can inspire participants to answer questions in detail and depth, hitting the finer points of the topic and seeing the layers of meaning (Rubin & Rubin, 2012). Rubin and Rubin (2012) also noted the importance of interviewers guiding and developing questions that encourage nuanced answers, rather than yes-or-no responses. I ensured that I abided by these helpful qualitative research practice recommendations. Additionally, I provided an introduction to the interview process and topic, then proceeded to the questions, and included a debriefing of the interview.

Data Analysis

In preparation for data analysis, I transcribed the interview recordings and reviewed each transcript at least three times, comparing them with the audio recordings to ensure accuracy. This thorough review process helped maintain the integrity of the data and ensured that the subsequent analysis was based on precise and accurate information (Patton, 2015). I employed thematic analysis following Saldaña's (2016) guidelines to identify patterns and themes in the interview data. Thematic analysis is a method used to identify, analyze, and report patterns and thematic categories based on participant data (Saldaña, 2021). This approach enables a thorough examination of the experiences and insights shared by the participants (Saldaña, 2021). Saldaña (2021) explained that the collected data could be coded and arranged into categories to help identify themes.

First, the transcribed data from the interviews were coded using descriptive and in-vivo codes. Descriptive codes summarized the primary topics within various parts of the transcripts, while in-vivo codes were directly drawn from participants' words (Saldaña, 2021). Ideally, these codes were used to capture the data surrounding decision making within various parts of the description and summarize the main points (Saldaña, 2021). Thus, the initial coding phase was used to focus on capturing key elements of decision making as described by the participants.

In the second phase of analysis, I identified categories from the initial codes. These categories were used to group similar codes, helping to organize the data and reveal patterns or relationships within the participants' experiences (Saldaña, 2021). In the final phase, I analyzed the categories to identify overarching themes. Themes were developed by examining the connections and relationships between categories, providing deeper insights into the decision-making process and the factors influencing it (Ravitch & Carl, 2021; Rubin & Rubin, 2012).

Additionally, I used hand coding over qualitative data analysis (QDA) software for this study. Although QDA software offered advantages in organization and time management, hand coding was used to ensure a higher level of immersion in the data. I used this method to engage more closely with the transcripts, obtain a higher level of immersion in the data, and develop a deeper understanding of the participants' perspectives (Patton, 2015).

Various methods were used to address the rigor and trustworthiness of the study, covering credibility, transferability, dependability, and confirmability. First, credibility in

qualitative research is similar to internal validity in quantitative research, focusing on whether the study's findings align with reality (Shenton, 2004). In qualitative research, credibility is demonstrated by the depth and authenticity of participant narratives, as well as the alignment of findings with their lived experiences. A credible study provides substantial empirical evidence for each conclusion (Rubin & Rubin, 2012). In the present study, several strategies were employed to enhance credibility, including participant honesty and peer review. Encouraging honesty among participants and subjecting the study to peer review were employed to enhance the credibility of this study (Ravitch & Carl, 2021). Specifically, I utilized my professional network for selection by emailing peers who met the inclusion criteria but would not be included in the sample to participate in the peer review process. Any feedback resulting from the peer review process was addressed, should the peers agree. If there was a discrepancy between the peers, I emailed them both for clarification and attempted to reach a consensus before implementing the changes.

Additionally, I engaged in peer debriefing with two licensed social workers outside of the study who had no vested interest in the outcomes (Tomaszewski et al., 2020). I used peer debriefing to navigate challenges, validate findings, and guide the research process. To facilitate this process, I asked two peers who were familiar with this area but had no active interest in this research to listen to the objectives of my study and how I planned to carry out the methodology. I will ask for feedback that may explain potential biases, shortcomings, or ideas I had not considered. Once peer debriefing was concluded, I made adjustments as necessary.

Second, I used strategies to ensure transferability. Transferability, or external validity, refers to the extent to which the study's findings can be applied to other contexts (Ravitch & Carl, 2021). To enhance transferability, I provided rich, thick descriptions. I provided detailed descriptions of the context of this study, including its participants and procedures for data gathering and analysis. By providing comprehensive contextual information, future researchers can more effectively evaluate the transferability or applicability of the findings to various contexts or population groups. This approach allows readers to make informed judgments about the relevance of the study's results to their own study and contexts.

Third, I employed strategies to ensure dependability. Dependability in qualitative research parallels the concept of reliability in quantitative studies. It refers to the consistency and stability of the study over time (Ravitch & Carl, 2021). To ensure dependability in this study, I employed a systematic and transparent approach to data collection and analysis. This process included maintaining detailed records of the research process, which would allow future researchers to understand how the study was conducted and assess its reliability.

Fourth, I employed strategies to ensure confirmability. Confirmability refers to the objectivity and neutrality of the findings in qualitative research. Unlike quantitative methods, which prioritize objectivity, qualitative research acknowledges my own influence and potential biases (Ravitch & Carl, 2021). Therefore, I first acknowledged my own status as a social worker employed at a local hospital where first evaluations and petitions for IVC were completed. Second, I acknowledged my role as a doctoral student

doing doctoral research in this field. To enhance the confirmability of this study, I also sought to maintain awareness of my personal experiences, opinions, and perspectives while exploring the experiences and views of this study's participants. This process was to prevent any personal bias surrounding my views on IVC for inpatient psychiatric treatment from confounding this study's results. Doing so was important in maintaining the integrity of the research process (Saldaña, 2021).

I maintained a reflexive journal to track my thoughts, decisions, and potential biases throughout the study, actively acknowledging personal biases and minimizing their impact on the research process and results. I also employed peer review and auditing as part of the confirmability process. As such, the gathered data from the interviews underwent peer review and, if possible, external auditing. These procedures were used to help validate the findings and ensure that the data supported the study's conclusions.

Ethical Procedures

In this study, ethical procedures were applied to protect the participants. This application included gaining prior approval from the school's IRB. The IRB approval for this study is 11-27-24-1085166. Another ethical procedure was the informed consent process, a critical component of ethical research. It was essential to ensure that participants in this study fully understood the study's purpose, procedures, risks, and benefits before agreeing to participate (Ravitch & Carl, 2021). To ensure this process, several steps were followed. First, potential participants received an invitation letter (see Appendix B) via email before the interview. This invitation letter outlined the study's objectives, the nature of their participation, and what to expect during the interview. The

invitation letter was also used to provide complete information about how the data were used, who had access to those data, and how those data were distributed (VandeVusse et al., 2022). This transparency was designed to foster trust and rapport with participants, promoting informed and voluntary participation.

Furthermore, I provided the informed consent form. This form was sent to participants via email, clearly outlining their rights, including the voluntary nature of their participation, the right to withdraw from the study at any time without penalty, and the right to decline answering any questions with which they might be uncomfortable. Before the interview, participants were asked to review the consent form, sign it if they agreed to participate, and return it prior to the interview. In addition to signing the informed consent form, this information was reiterated and reviewed again on the day of the interview. That is, I verbally reviewed the key points of the informed consent form with each participant to ensure they fully understood their rights and the procedures of this study. This verbal consent process also provided an opportunity for participants to ask any additional questions or clarify concerns before proceeding with the interview.

I debriefed participants after the interviews. They were thanked for their time and provided with an additional opportunity to request resources, such as referrals to therapeutic professionals, in case they needed psychological support following the interview. This debriefing process ensured that participants left the study feeling supported and informed of the full process of this study.

The ethical protection of participants was paramount in this qualitative research study. Several measures were implemented to ensure that the participants were ethically

protected throughout the research process. First, I did not proceed with any study procedure without IRB approval. Additionally, each participant was informed of the potential risks associated with the interview, including the possibility of recalling unpleasant memories. To mitigate these risks, I prepared a list of referrals to mental health professionals, which was made available to participants in case they needed psychological support after the interview. This proactive approach aligned with ethical guidelines to protect participants from harm (Ravitch & Carl, 2021).

Additionally, each participant was explicitly informed that their participation was voluntary to ensure the ethical protection of participants. They had the right to skip any questions they did not wish to answer, stop the interview at any time without penalty, and withdraw from the study altogether if they chose to do so. This process ensured that participants remain in control of their involvement, reducing the likelihood of distress or discomfort (Ravitch & Carl, 2021).

Maintaining participant confidentiality was also a significant priority in this study. To ensure that all participant data were kept confidential, all gathered data were anonymized. Each participant was assigned an alphanumeric code that replaced any identifying details in the raw data, including transcribed data. Therefore, all identifying information was removed or omitted from the data results and analysis.

Furthermore, all digital data gathered for this study were securely stored in a password-protected USB file. Any hard-copy data, such as printed transcripts or consent forms, were securely stored in a locked filing cabinet. Only I, as the researcher of this study, had authorized access to the data. Participants were informed about these

confidentiality and data storage measures during the informed consent process. All raw data will be securely destroyed and deleted 5 years after the publication of this research. That is, digital files will be deleted, and hard-copy data will be destroyed using a crosscut shredder to ensure that no identifying information remains. These confidentiality and data security measures were clearly communicated to participants during the informed consent process, ensuring they were fully aware of how their information was handled and protected throughout the study.

Summary

The lack of existing research on the decision-making experiences of social workers as first evaluators for IVCs was a gap that this study aimed to address. Despite this lack of research, social work is a highly stressful profession due to its conflicting roles and functions. Ethical conflicts are likely to arise in a social worker's career due to various factors, including personal values and beliefs (Ife et al., 2022). Social workers also experience high pressure to avoid mistakes that could harm their clients or create agency liability concerns (Ife et al., 2022). This study aimed to explore and understand how licensed clinicians, specifically social workers, in North Carolina described their experience and decision to place clients under IVC for inpatient psychiatric treatment while balancing legal and ethical responsibilities.

I selected a basic qualitative design as the methodology for this study. Using a biomedical ethics framework, I conducted semistructured interviews to understand better the decision-making process for social workers completing first evaluations for IVC to inpatient psychiatric treatment. The expected number of participants for this study was

between 10 and 12, or until data saturation was reached. Participants were certified as first evaluators in North Carolina. Participants were provided with informed consent before the interviews. The identities and personal information of study participants remained confidential, and only data analyses were reported in study findings, documents, and presentations. The study data were analyzed through qualitative coding analysis. I maintained credibility, trustworthiness, and validity in this study by providing a detailed explanation of the methods, allowing for the replication and application of the research findings. The following section presents the study's findings.

Section 3: Presentation of the Findings

Introduction

In this qualitative study, I explored how licensed social workers described their experiences and decision-making processes when determining whether to place clients under IVC while balancing legal and ethical responsibilities. IVC is a complex and ethically charged process requiring social workers to balance legal mandates with client rights. This study explored how licensed social workers navigated these tensions in North Carolina. Data were collected through one-to-one, semistructured interviews with 12 LCSWs in North Carolina. This study addressed the following RQs:

- RQ1. What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment?
- RQ2. What ethical, legal, or administrative issues tend to compound this process?
- RQ3. What factors facilitate this decision-making process?
- RQ4. What type of ethical conflicts surround this process and how are they resolved in the field?
- RQ5. What specific principles of biomedical ethics are present in the decision-making process? How do they affect the decision-making process?
- RQ6. What recommendations do social workers have for needed policy changes that will facilitate the IVC process?

The purpose of this section is to present the findings that emerged from conducting the data collection and data analysis procedures described in Section 2. The following section indicates the data analysis techniques employed in this study. This section presents the study findings, organized by RQs. This section concludes with a summary of the findings.

Data Analysis Techniques

The group of interest for this study included LCSWs in North Carolina who had completed the certification process to become first evaluators for IVC and were employed in various agencies. Participants were recruited using multiple avenues, including contacting the North Carolina Chapter of the NASW (2021) via their listserv. The North Carolina Department of Health and Human Services also listed those who had received certification as first evaluators.

Another recruitment strategy involved contacting locations that served as first evaluation sites in North Carolina. I obtained organizational approval from each evaluation site, determining if their supervisor would allow for the distribution of a study announcement and invitation. The approved organizational letter coming from the respective department head within the organization was presented and provided to Walden University's IRB.

In preparation for data analysis, I transcribed the interview recordings and reviewed each transcript at least three times, comparing them with the audio recordings to ensure accuracy and consistency. This thorough review process helped maintain the integrity of the data and ensured that the subsequent analysis was based on precise and

accurate information (Patton, 2015). To analyze the interview data, a thematic analysis was conducted following the guidelines set forth by Saldaña (2016) for this qualitative research study. Thematic analysis was a method used to identify, analyze, and report patterns and thematic categories based on participant data (Saldaña, 2021). This approach enabled a thorough examination of the experiences and insights shared by the participants (Saldaña, 2021).

First, I coded the transcribed data from the interviews using descriptive and in-vivo codes. Descriptive codes summarized the primary topics within various parts of the transcripts (Saldaña, 2021). These codes captured the data surrounding decision making within various parts of the description and summarized the main points (Saldaña, 2021). Thus, the initial coding phase focused on capturing key elements of decision making as described by the participants. In the second phase of analysis, I identified categories from the initial codes. These categories were grouped to organize similar codes, helping to reveal patterns or relationships within the participants' experiences (Saldaña, 2021). Table 1 presents the initial codes and their grouping to identify categories during the second phase of analysis. Appendix D contains the codebook for the study.

Data Saturation

Data collection concluded after 12 participant interviews, when no new codes or concepts emerged across two consecutive interviews. This point was considered evidence of thematic saturation. Given the study's focused aim, sample specificity, and strong interview quality, the data demonstrated adequate information power (Malterud et al.,

2016) to comprehensively address the RQs. The final data set provided sufficient breadth and depth to support credible, well-developed themes.

Table 1

Initial Codes and Corresponding Categories

Initial code	Category
Assessing patient presentation	Assessment experiences
Evaluating all relevant factors	
Meeting patient needs	
Personal values aligned with professional ethics	Experiences of value alignment
Working within first evaluator parameters	
Focusing on code of ethics and safety	Ethical issues
Keeping patient informed	Legal issues
Consideration of immediate risk	
Ensuring patient safety	Patient factors
Evaluating risk and protective factors	
Mitigating patient resistance	Provider factors
Aiming to keep IVC rates down	
Experience as an advantage	External considerations
Pressure from family members	
Pressure from providers	Patient-centered considerations
Patient autonomy and self-determination	
Potential for imminent harm	IVC policy recommendations
Choice in facility would benefit patients	
Clarity regarding substance abuse IVC	Judicial recommendations
More specificity needed in criteria of imminent harm	
Barriers to access for petitioning	
More consistent training of magistrates	

Note. IVC = involuntary commitment.

In the final phase, I analyzed the categories to identify overarching themes. Themes were developed by examining the connections and relationships between categories, providing deeper insights into the decision-making process and the factors influencing it (Ravitch & Carl, 2021; Rubin & Rubin, 2012). Table 2 presents the categories and their grouping to identify themes.

Table 2*Categories and Final Themes*

Category	Final theme
Assessment experiences	Holistic assessments within ethical boundaries
Experiences of value alignment	
Ethical issues	Code of ethics, respect for the patient, and ensuring safety
Legal issues	compounded decision making
Patient factors	Experience, knowledge of patients, and assessment of risk
Provider factors	and protective factors facilitated decision making
External considerations	Protection of patient autonomy was balanced against risk
Patient-centered considerations	of imminent harm
IVC policy recommendations	More training for magistrates, more clarity in IVC policy,
Judicial recommendations	and more choice in facilities were recommended

Note. IVC = involuntary commitment.

I used various methods to address the rigor and trustworthiness of the study.

These were credibility, transferability, dependability, and confirmability. First, credibility in qualitative research is similar to internal validity in quantitative research, focusing on whether the study's findings align with reality (Shenton, 2004). A credible study provides substantial empirical evidence for each conclusion (Rubin & Rubin, 2012). Several strategies were used to enhance credibility, such as participant honesty and peer review. Encouraging honesty among participants and subjecting the study to peer review helped strengthen the credibility of this study (Ravitch & Carl, 2021).

Specifically, I used my professional network for selection by emailing peers that fit the inclusion criteria, but who were not used in the sample, to participate in the peer review process. Additionally, this study applied peer debriefing, which was crucial in qualitative research for maintaining credibility and trustworthiness (Tomaszewski et al., 2020). I used peer debriefing to navigate challenges, validate findings, and guide the

research process. To do this process, I asked two peers who have knowledge in this area but no active interest in this research to listen to the objectives of my study and how I planned to carry out the methodology. I asked for feedback that could explain potential biases, shortcomings, or ideas I had not considered. Once peer debriefing was concluded, I adjusted as necessary.

Second, I utilized strategies to ensure transferability. Transferability, or external validity, refers to the extent to which the study's findings can be applied to other contexts (Ravitch & Carl, 2021). To enhance transferability, I provided rich, thick descriptions. I documented detailed descriptions of the context of this study, its participants, and procedures for data gathering and analysis. By offering comprehensive contextual information, future researchers can better evaluate the transferability or applicability of the findings to different contexts or population groups. This approach allows readers to make informed judgments about the relevance of the study's results to their study and contexts.

Third, I utilized strategies for dependability. Dependability in qualitative research parallels the concept of reliability in quantitative studies. It refers to the consistency and stability of the study over time (Ravitch & Carl, 2021). I employed a systematic and transparent approach to data collection and analysis to ensure dependability in this study. This process included maintaining detailed records of the research process, which would allow future researchers to understand how the study was conducted and assess its reliability.

Fourth, I utilized strategies for confirmability. Confirmability refers to the objectivity and neutrality of the findings in qualitative research. Unlike quantitative methods, which prioritize objectivity, qualitative research acknowledges my own influence and potential biases (Ravitch & Carl, 2021). Therefore, I first acknowledged my status as a social worker employed at a local hospital where first evaluations and petitions for IVC were completed. Second, I acknowledged my role as a doctoral student doing doctoral research in this field. To enhance the confirmability of this study, I also sought to maintain awareness of my personal experiences, opinions, and perspectives while exploring the experiences and views of this study's participants. This process was to prevent any personal bias surrounding my views on IVC for inpatient psychiatric treatment from confounding this study's results. Doing so was important in maintaining the integrity of the research process (Saldaña, 2021).

I maintained a reflexive journal to track thoughts, decisions, and potential biases throughout the study to actively acknowledge personal biases and take steps to minimize their impact on the research process and results. I also employed peer review and auditing as part of the confirmability process. As such, the gathered data from the interviews underwent peer review. These procedures helped validate the findings and ensured that the study's conclusions are supported by the data.

Researcher Reflexivity

As an LCSW and first evaluator in North Carolina, I brought professional experience and personal perspectives to this study. Because of my proximity to the phenomenon under investigation, I engaged in reflexive practices throughout data

collection and analysis to minimize bias. I maintained a reflexive journal to record assumptions, decisions, and emotional reactions, which allowed me to bracket personal experiences from participants' accounts. Peer debriefing was also used to test interpretations and challenge emerging assumptions. These strategies promoted transparency and helped ensure that the findings represented participants' perspectives rather than my own professional views.

Findings

This presentation of the findings is organized by RQs. Under the heading for each RQ, the theme that was identified during data analysis to address the question is presented. Direct quotes from the data are provided as evidence for the themes.

Research Question 1

RQ1 was the following: What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment? The theme that emerged during data analysis to address this question is discussed in the following subsection.

Theme 1: Holistic Assessments Within Ethical Boundaries

This theme indicated the general experiences of the participants when completing IVC first evaluations. The theme emerged from grouping two categories. Table 3 indicates the categories that were grouped to form this theme and the initial codes that were grouped to form the categories. A more detailed presentation of the categories follows.

Table 3*Theme 1 Categories and Codes*

Theme	Category	Initial code	No. of text segments assigned	%
Experience included evaluating all relevant factors and working within first evaluator ethical parameters.	Assessment experience		38	31
			28	23
		Assessing patient presentation	7	6
	Experiences of value alignment	Evaluating all relevant factors	13	11
		Meeting patient needs	8	7
		Personal values aligned with professional ethics	10	8
	Working within first evaluator parameters	7	6	
		3	2	

Category: Assessment Experiences. Twelve participants contributed data to this category, which was identified by grouping three related initial codes. The first initial code grouped was assessing patient presentation. Six of the participants contributed data to this code. The finding indicated that participants' general experiences of conducting IVC evaluations included assessing how patients presented to infer the patient's mental state and any risk they might pose to themselves or others. In a representative response, P7 described the factors that they and other participants looked for when assessing patient presentation:

Of course, assessing for any suicidal, homicidal ideations. Assessing for any kind of hallucinations, any hallucinations that are command in nature. Trying to determine any recent history. Determining whether or not the person is able to make a decision on their own, if they're able to engage and commit to treatment,

and if they're not able to understand or to accept, then there's all these safety concerns. Then that's when I will make a decision to do an involuntary commitment for them.

P7 indicated that the key factor they looked for when assessing patient presentation was any indication of a safety concern. In another representative response, P9 provided corroboration of P7's report that indications of safety concerns were the paramount consideration when assessing patient presentation:

A lot of times, I like to focus on the mental status exam first. So, are they oriented to where they are, date, time. Are their mood and affect congruent? What's their speech like? Are they displaying any signs of psychosis or mania? Pressured speech, flight of ideas. Are they admitting to any kind of hallucinations? Because I think those are more of the obvious symptoms that could present as potentially dangerous or someone putting themselves in a dangerous situation.

As with P7, P9 indicated that assessing patient presentation involved looking for signs that the patient might be a danger to themselves or others. Such signs included hallucinations, disorientation, evidence of homicidal or suicidal ideations, and indications of mania or psychosis.

The second code grouped to form the assessment experiences category was evaluating all relevant factors. Ten participants contributed data to this code. The finding indicated that even though factors such as those discussed under the previous code were primary considerations when making an IVC evaluation, all relevant factors were considered. In a representative response, P4 explained, "If you look at people as just a

piece of paper, you're doing everybody a disservice, because people are more than their individual pieces of them, and an individual person, you have to look at the whole picture.” The idea of looking at the broader context was central to the finding in this initial code. P8 explained why looking at the whole picture was important, in another representative response: “The more you know about the patient, the better and more informed decisions you can make . . . If you are called into court, you want to be able to vouch [for] and stand by what you did.” Considering all relevant factors was important because it contributed to better decision making, P8 indicated that better decision making was easier to justify in the event of a court appearance. P7 noted that part of considering the whole picture was considering the patient’s culture: “Keeping in mind that their own cultural experiences are important, that if they are coming from Hispanic culture, then I'm able to see things from a different perspective than maybe other people wouldn't.” The participants indicated that considering all relevant factors, or the whole picture, contributed to better decision making, and that one of the relevant factors was the patient’s cultural background.

The third code grouped to form the category assessment experiences was meeting patient needs. Eight participants contributed data to this code. The finding indicated that one of the participants’ experiences of assessment was trying to conduct the assessment in such a way that they would meet the patient’s needs. P11 said in a representative response, “Knowing that I'm being helpful to patients is how I define success.” In another representative response, P2 said that a goal during assessment was to “hopefully create some impact or change for that patient.” P5 said of the goal of assessment, “I would

define success as helping people who have struggled or are in the midst of struggling with something.” According to the participants, the goal of assessment was to have a positive impact on the patient’s condition and help meet the patient’s needs.

Category: Experiences of Value Alignment. The second category grouped to form Theme 1 was experiences of value alignment. Nine participants contributed data to this category. This category was formed by grouping two initial codes. The first of those initial codes was personal values aligned with professional ethics. Seven participants contributed data to this code. P4 provided a representative response indicating that helping patients was a personal value and a professional obligation:

One of the reasons why I go back to the Social Work Code of Ethics is because it matches my personal code of ethics in many ways. Making sure that people get connected to the health they deserve, even if they're not able to consent to that, or not willing to consent to that, I think it means a lot to me.

P4 reported alignment between personal values and professional ethics specifically in getting help for patients who needed it. P12 offered a similar perspective in another representative response:

I think just as a person, my own personal view is that it's my responsibility, and I guess it kind of overlapped [with my professional ethics], 'cause I just feel like, personally, it’s my responsibility to make sure that people are safe.

The participants indicated, in data assigned to this code, that their experiences of assessment included an alignment or overlap between their professional obligation to

ensure that patients who needed help received it, and their personal commitment to helping those in need.

The second initial code grouped to form the experiences of value alignment category was working within first evaluator parameters. Three participants contributed data to this code. The participants indicated that first evaluator parameters were broad, and their own values and standards necessarily guided their decision making within that framework. P4 explained,

I am working within the parameters of the first commitment evaluator training and their expectations. Now those expectations are pretty broad at times, so that's where I find success is like being comfortable in my decision making and knowing that I'm not just committing everybody or letting everybody go, but I'm actually taking into account the whole picture and making good decisions.

P4 reported that the importance they placed on good decision making when making IVC evaluations guided them within the broad parameters of her role, such as by prompting the to look at the whole picture. P1's commitment to upholding the patient's right of self-determination guided their decision making: "Making sure whenever we are completing those exams, giving the client the right to self-determination is important, and I think the only way they don't have that right is whenever they are a danger to themselves or others." Upholding the patient's right to self-determination was also an ethical obligation; thus, P1's personal values were aligned with professional ethics.

Research Question 2

RQ2 was the following: What ethical, legal, or administrative issues tend to compound this process? One theme emerged during data analysis to address this question. The theme is discussed in the following subsection.

Theme 2: Code of Ethics, Respect for the Patient, and Safety Measures as Factors Compounding Decision Making

This theme indicated the ethical and legal issues that compounded IVC first evaluations. The theme emerged from grouping two categories. Table 4 indicates the categories grouped to form this theme and the initial codes grouped to form the categories. A more detailed presentation of the categories is provided in the following subsection.

Table 4

Theme 2 Categories and Codes

Theme	Category	Initial code	No. of text segments assigned	%	
Code of ethics, respect for the patient, and ensuring safety compounded decision making.	Ethical issues		19	16	
			10	8	
		Focusing on code of ethics and safety	7	6	
			Keeping patient informed	3	2
	Legal issues			9	7
			Consideration of immediate risk	3	2
			Ensuring patient safety	6	5

Category: Ethical Issues. The category of ethical issues was formed by grouping two related codes, and it included data from eight participants. The first initial code

grouped to form this category was focusing on the code of ethics and safety. This code included data from seven participants, and it indicated that the code of ethics and safety was an influential or compounding factor in the IVC evaluation process. P6 reported that sometimes professional ethics conflicted with personal feelings of sympathy, or a desire to accommodate the patient's wishes:

I try to use the code of ethics in all of my social work practice, and that involves, sometimes, the best way I can say it is sometimes you don't feel good personally about the decisions you have to make. Sometimes you'll have somebody begging you not to IVC them, but I think my professional values come into play there, where I know, while this may not feel good for me, this is what is ultimately safest for the individual, and that's in line with my professional ethics.

P6 indicated that they sometimes felt uneasy with committing patients who expressed strong opposition to that course of action, but that if an IVC was necessary for the patient's or someone else's safety, the participant's professional ethics required that they evaluate the patient accordingly. P1 indicated that when patients engaged in risky behaviors without intent to cause harm to themselves or others and family members urged an IVC, fulfilling the ethical obligation to uphold the patient's right to self-determination could be difficult:

I think it can get really muddy in the substance use area, and maybe engaging in risky behavior but not intentionally wanting to harm themselves or other people, I think sometimes that can come a little bit muddy, especially if the family

members that are involved, and just reminding, you know, of the right to self-determination and things along those lines can be a difficult decision.

P1 reported that a patient might place themselves at considerable risk without intending self-harm, including in cases of substance abuse. In such cases, the danger to the patient might make an IVC seem appropriate, but the ethical obligation to uphold the patient's autonomy would outweigh this consideration when the patient did not intend harm to themselves or others.

The second code grouped to form the ethical issues category was keeping the patient informed. Three participants contributed data to this code. The finding indicated that the ethical obligation to keep the patient informed could be a complicating or compounding factor. P3 said that when deciding to commit a patient involuntarily, "then I explain to them what's going to happen next, and sometimes it's not a great conversation." P3 indicated that keeping patients informed could be difficult when the information a patient had a right to receive indicated a course of treatment to which the patient objected. Part of keeping the patient informed included giving them information they could use to advocate for themselves, P10 added, "It's important that we know the law and that we can explain it to them. And if they don't want to stay, we have to be very knowledgeable of what the law states." Informing patients of their rights provided them with a tool to resist the IVC, but keeping them informed was an ethical obligation.

Category: Legal Issues Related to Balancing Autonomy and Risk. Eight participants contributed data to this category, which was identified by grouping two related codes. The first code was a consideration of immediate risk. This code included

data from three participants. The participants indicated that their legal obligation to consider the risk of imminent harm to the patient or others sometimes conflicted with their desire to spare the patient additional distress:

I have to think about as much as I would hate being transported in handcuffs, or someone who has a history of law enforcement or incarceration, and I know how traumatic that will be, and they don't want to be locked up or something. I have to remind myself that they literally are a danger to themselves if they leave, right, if they've expressed suicidal ideation. And I have to remind myself that that outweighs potential stress of that process, and so, to me, it's reminding myself why the involuntary commitment process exists.

P9 noted that being forcibly restrained and removed to a psychiatric hospital could be traumatic, and the desire to spare patients that trauma could make a practitioner reluctant to commit them involuntarily. However, the legal obligation to ensure the patient's safety necessarily outweighed the desire to spare them additional distress. P4 also discussed how the legal obligation to consider the risk of imminent harm could determine the sometimes-uncomfortable decision to commit a patient involuntarily:

Looking at the immediate, imminent harm to self or others, or serious property damage. And you have to fall back to that, too. So, I think if you look at those things to give you the full picture, it helps with that ethical tension. You may not feel good about what you do, but you know that you're acting within your code of ethics.

P4 indicated that following legal requirements reassured them that they were acting within her professional code of ethics.

The second code, grouped to form the legal issues category, was patient safety. Six participants contributed data to this code. The finding indicated that although the obligation to keep patients safe sometimes conflicted with the obligation to uphold patient autonomy, the priority given under the law to considerations of safety enabled the participants to feel that preventing a patient from harming themselves or others was an unequivocal success, despite the deprivation of autonomy. P7 expressed this view: “I think, overall, the most important thing is safety. And I think, at the same time, it is also knowing that you're respecting their decision making, to a certain extent, unless it means safety is compromised.” P7 indicated that the obligation to uphold patient autonomy could be compromised by legal necessity when a threat of imminent harm existed. P1 agreed,

The main priority is keeping everybody safe, and making sure that we are using the involuntary commitment correctly, in terms of making sure that whoever is involuntarily committed needs to be there . . . [because] they were a danger to themselves.

Like P7, P1 indicated that the legal prioritization of safety contributed to resolving the ethical conflict between ensuring the safety of the patient and others and upholding patient autonomy. These responses demonstrate how participants navigate the complex moral terrain while upholding both legal mandates and professional ethical standards.

Research Question 3

RQ3 was the following: What factors facilitate this decision-making process? One theme emerged during data analysis to address this question. The theme is discussed in the following subsection.

Theme 3: Experience, Knowledge of Patient, and Assessment of Risk and Protective Factors as Facilitators of Decision Making

This theme indicated the factors that facilitated the IVC decision-making process. This theme represents how clinicians relied on both the patient's personal context and their own clinical judgment to inform IVC decisions. Both patient-specific elements and provider experience were critical to navigating the complexities of IVC. The theme emerged from grouping two categories. Table 5 lists the categories grouped to form this theme, along with the initial codes used to create these categories.

Table 5*Theme 3 Categories and Codes*

Theme	Category	Initial code	No. of text segments assigned	%
Experience, knowledge of patient, and assessment of risk and protective factors facilitated decision making.	Patient factors	Evaluating risk and protective factors	20	17
		Mitigating patient resistance	10	8
	Provider factors		4	3
			10	8
			2	2
		Aiming to keep IVC rates down	8	7
		Experience as an advantage		

Note. IVC = involuntary commitment.

Category: Patient Considerations. Two patient-specific considerations were salient: the assessment of risk and protective factors and the provider's ability to mitigate patient resistance through relationship-building. This category indicated patient factors that facilitated IVC decision making, and it was formed by grouping two related codes that included data from a total of seven participants. The first code grouped to form this category was evaluating the patient's risk factors and protective factors. Four participants contributed data to this code, indicating that considering the patient's risk and protective factors facilitated informed vascular access decision making. P5 discussed the weighing of risk factors against protective factors, saying that IVC decision making was facilitated by the following:

Trying to judge if they can recognize the risks that are being discussed, and then I would say afterwards determining . . . whatever the risk is for harm. So, if the safety plan is good enough, potentially considering not doing the first evaluation with the final outcome of an involuntary commitment, and trying to do the least restrictive.

For P5, protective factors included the patient's ability to understand the risk of harm and their ability to understand and follow a plan for averting that risk. Risk factors included the risk of harm. If safety factors outweighed risk factors, then an IVC might not be necessary, as P5 indicated. P6 also discussed the weighing of risk factors against protective factors:

I look at risk and protective factors. So, you know, there's some obvious signs of risk for suicidality, or harm to self or others, but I think it's equally as important to also look at what protective factors they have in place, as well, which could be like supports. Are they on medication? Did they seek help voluntarily? Do they have a history? So, yeah, I'm looking at all of those things.

P6 reported weighing the risk of harm to self or others against protective factors, such as medication compliance and voluntary help-seeking.

The second code, grouped to form the category of patient factors, was mitigating patient resistance. This code included data from five participants. P8 indicated that getting to know the patient facilitated IVC decision making by helping to establish a foundation of trust and rapport that might make the patient less resistant:

You build rapport and communicate with someone. I think once you spend time with someone . . . getting to know them, talking to them, explaining things to them, making sure they are very aware of what is actually taking place and how things work, that right there creates a relationship where they essentially trust you.

A patient who believes the provider has taken the time to get to know them might be more accepting of an IVC decision than a patient who does not feel heard, as P8 suggested. P4 also described getting to know the patient as essential for mitigating their resistance to treatment:

We have to get to know our people, because sometimes people don't want help because they have a misunderstanding of what that means. Sometimes they don't understand what medications do. Sometimes, they've had bad reactions to medications, and their families have done things that have been harmful, and so I think it's important to understand the why, why they might not be seeking help, and to address that root issue. I know we're limited in that when we're doing the first evaluations, but we can certainly plant seeds. We can start that process.

P4 indicated in this response that a provider was unlikely to overcome a patient's resistance to treatment entirely during the IVC process (otherwise, IVC would not be necessary). However, a provider could at least begin the long-term process of persuading the patient to comply with treatment. Moreover, this effort could begin to mitigate resistance and facilitate the IVC process to some extent.

Category: Provider Factors. Two provider-based elements influenced IVC decisions: external pressure to reduce IVC rates and accumulated clinical experience,

which provided a broader context for evaluating patients. While some providers described administrative discouragement of IVC, others emphasized how their clinical background enabled them to make more nuanced assessments of risk. The second category, grouped to form Theme 3, was provider factors. This category was formed by grouping two initial codes, and it included data from a total of eight participants. The first code grouped to form this category was aiming to keep IVC rates down. Two participants contributed data to this code, and the findings indicated that an influence on providers during the IVC decision-making process was that IVCs were discouraged in some facilities. P11 stated that IVC decision making was sometimes facilitated because “Here at this hospital, it's [IVC is] discouraged,” with the result that doubts were resolved in favor of not involuntarily committing the patient. P2 described a similar situation, saying, “At least for my hospital setting, we really wanna try to keep those involuntary commitment rates down,” with the result that doubts were resolved in favor of releasing the patient if they could not be persuaded to accept treatment voluntarily.

The second initial code, grouped to form the provider factors category, was experience as an advantage. This code included data from seven participants, indicating that experience facilitated their IVC decision making. P8 explained,

Due to me just having a variety of different roles that I've worked in in the past, I feel like it has a positive impact on my decision making because I have seen people in crisis. But I've also seen people when they're not in crisis. I think that the more experience you have dealing with people in different settings, you can

better assess and make a determination that's not just based off of what's going on in that moment.

P8 indicated that experience provided a baseline or basis for comparison when assessing whether a patient was in crisis or a danger to themselves or others. P2 agreed, I did outpatient for about 5 or 6 years, and then working in hospital-based practice, I've seen a wide variety of mental health issues, and so really being able to know, for example, what schizophrenia looks like when that patient is stable, and knowing what that looks like when they're decompensated. So, my wealth of experience in seeing all these different diagnoses helps me to know when it's risen to the high-level end of an acute crisis.

Like P8, P2 indicated that experience in evaluating patients facilitated IVC decision making by providing a basis for comparison in assessing whether a patient was in crisis or a danger to themselves or others.

Research Question 4

RQ4 was the following: What type of ethical conflicts surround this process and how are they resolved in the field? One theme emerged during data analysis to address this question. The theme is discussed in the following subsection.

Theme 4: Protection of Patient Autonomy Balanced Against Risk of Imminent Harm

Theme 4 addressed the ethical tension between upholding patient autonomy and mitigating imminent harm. Two key categories emerged: external pressures influencing decision making and internal considerations related to patient rights and safety. Table 6

outlines the categories grouped to form this theme, along with the initial codes used to form the categories.

Table 6

Theme 4 Categories and Codes

Theme	Category	Initial code	No. of text segments assigned	%
Protection of patient autonomy was balanced against risk of imminent harm.	External considerations		29	24
			9	7
		Pressure from family members	1	1
	Patient-centered considerations	Pressure from providers	8	7
			20	17
		Patient autonomy and self-determination	14	12
	Potential for imminent harm	6	5	

Category: External Considerations. Nine participants contributed to this category, indicating that pressures influencing IVC decision making extended beyond or were external to the weighing of the imminent risk of harm against the importance of patient autonomy. One of the external considerations was indicated by the first code, pressure from family members, as noted by data from one participant. These pressures arose when the clinician's judgment conflicted with pressure from providers or family. Pressure from providers or family would not cause the clinician to act against their own judgment; however, it would be considered part of the holistic assessment of the client's condition. P4 explained, "You'll get pressures from family members, and that can go

either family or friends. You get pressures from both ways—don't hospitalize, do hospitalize.” P4 indicated that for social workers to address this pressure without letting it influence them unduly, “you have to justify your decision-making process.” However, input from family and friends should be considered as relevant factors, or part of the whole picture, as indicated under Theme 1.

Eight participants contributed to the code pressure from providers, indicating that medical providers could pressure social workers to make IVC decisions with which the social workers did not agree. P1 discussed this pressure:

I think one of maybe the external [pressures] could be like in the emergency room, where you work as a team with the doctor, sometimes the doctor might have a different opinion than us. And so, sometimes, that could be an external influence on the decision, if the doctor feels like there may be more of a safety risk than [we do], and we try to advocate for the patient as much as we can.

P1 indicated that advocating for the patient was one way to address pressure from providers. P4 described another way in which social workers could address pressure from providers to make an IVC decision with which they disagreed:

Early in my career, I would have pretty much done whatever the physician said. But now, recognizing that we are social workers, and we are trained, and we are licensed, and we have our own license to protect as well, I can tell a physician if you disagree with me, you can do it differently and attach your name to it.

P4 indicated that they would refuse to make an IVC determination that went against their professional judgment, and they would address pressure from doctors by inviting them to make the determination themselves if they disagreed.

In my experience, pressure from family is inevitable and not as much of an ethical concern. However, when providers attempt to influence clinical decision making, this should be considered from an ethical perspective and viewed in a more negative light—especially when the pressure comes from a medical provider who lacks the specialized training in IVCs that social workers receive. In developing this theme, I remained mindful of my potential bias in favor of more serious consideration of provider pressure. I worked to mindfully set it aside so that it would not influence the development or presentation of this finding.

Category: Patient-Centered Considerations. This category comprised data from 11 participants, formed by grouping two related initial codes. Overall, the category indicated that the primary ethical conflict involved in IVC decision making was the need to balance the obligation to respect the patient’s autonomy against the obligation to ensure the patient's and others' safety. The first code associated with this category, patient autonomy and self-determination, indicated 10 of the participants’ perceptions of the first of these conflicting factors. P4 discussed the importance of respecting patients’ autonomy: “We care a lot about self-determination and autonomy, and it's like, okay, how grave of a situation does this have to be to take this away from someone?” P4 expressed the perception that upholding patients’ autonomy was important to social workers, and only a “grave” risk of imminent harm could justify depriving a patient of

their freedom. P3 explained that upholding the duty to respect patients' autonomy involved not depriving them of their freedom unnecessarily, by

trying to make sure that they can remain having that autonomy to their decision making and their involvement in their treatment. So, I do try to prioritize that . . . [and] I don't like to go that route of involuntary commitment. I try to keep them in that spot of the decision-maker for as long as possible.

"As long as possible" meant as long as safely possible, as P12 clarified, "It is our role, it is our job, to make sure that the [patient's] decisions do not end their life, do not end someone else's life." Thus, the conflict between patient autonomy and safety would be resolved in favor of safety when protecting the patient's autonomy would pose an imminent risk of harm to themselves or someone else.

The code potential for imminent harm included data from six participants, indicating the factor that the participants described as weighing against their obligation to respect the patient's autonomy. P11 said that the factors included in assessments of risk included the following:

If they're going to actually go out and possibly hurt themselves . . . or they're saying they're going to go out and kill themselves—and also, if they're threatening other people's lives and they're able to name the person—then those things are taken into consideration.

P11 indicated that these risks of imminent harm to the patient or others overrode the obligation to respect the patient's autonomy. In another representative response, P10 also described the risk of imminent harm as dispositive:

The most important thing is the sanctity of life. I want people to live. I don't want them to take their lives. I don't want them to hurt anyone else, so it is very important that if someone is contemplating suicide, or if someone is trying to hurt someone else, for me to keep that other person safe, and to make sure that everyone loves.

P10 described mitigating risks of imminent harm to the patient or others as “the most important thing,” in the sense that it outweighed considerations of the patient’s autonomy or considerations of family or provider pressure.

Research Question 5

RQ5 was the following: What specific principles of biomedical ethics are present in the decision-making process? One theme emerged during data analysis to address this question. The theme is discussed in the following subsection.

Theme 5: Centrality of Principles of Beneficence and Nonmaleficence to Decision

Making

These principles often guided social workers’ justifications for IVC, especially in ethically ambiguous situations where autonomy and safety were in tension. This theme reflected systemic and procedural gaps identified by participants that, if addressed, could improve patient outcomes and ethical alignment in the IVC process. This research examined how IVCs infringe on a client’s rights and autonomy during the treatment process. When individuals facing mental health concerns desire treatment, policies should prioritize voluntary inpatient treatment over encouraging IVC (Substance Abuse and Mental Health Services Administration, 2019). Understanding how clinicians navigated

these policies during the evaluation process was vital. Social workers strive to respect autonomy and self-determination, values that align with the care continuum, while IVCs, as a legal issue, align with the justice continuum.

This theme was derived from one initial code: Beneficence and nonmaleficence were central to decision making. The theme and code included data from nine participants. In a representative response, P8 explained why beneficence and nonmaleficence were central to IVC decision making:

An IVC is used for those things [beneficence and nonmaleficence]. You want to do something that is going to help the patient, but you also want to make sure they're not going to cause any harm, and so I think that both of those terms pretty much define what an IVC is used for and to prevent.

P8 reported that beneficence was central to IVC decision making because one of the purposes of IVC was to do good for the patient. Nonmaleficence was central to decision making because the other purpose of IVC was to prevent harm, P8 added. P1 agreed, saying, "Being the social worker, wanting to help others [beneficence], I think, and then doing no harm [nonmaleficence] weigh heavily" in IVC decision making. P2 noted, "I do think that sometimes maybe the patient may feel like harm is being done to them through this [IVC] process." The way to resolve that concern, P2 added, was for the social worker to "do what is considered the least restrictive for a patient and ensuring their voice is heard." Beneficence was central to IVC decision making because one of the primary purposes of IVC was to help the patient. Nonmaleficence was also central, as another purpose was to prevent harm to the patient and others. To the extent that patients

might perceive IVC as harmful to them, the solution was to ensure that the patient's voice was heard and that the least restrictive treatment that would adequately mitigate the threat of harm was imposed.

I was pleased to see this theme emerge, as it indicated a potential desire for improvement in patient outcomes and ethical alignment in the process. It is difficult to determine if it causes harm or not, as we do not receive follow-up after the fact. We do see some patients again, but not often. During data collection, analysis, and reporting, I remained mindful of my own opinions and worked to suspend any biases that might have resulted.

Research Question 6

RQ6 was the following: What recommendations do social workers have for needed policy changes that will facilitate the IVC process? One theme emerged during data analysis to address this question. The theme is discussed in the following subsection.

Theme 6: Recommendations for More Training for Magistrates, Clarity in IVC Policy, and Choice in Facilities

The findings reveal actionable recommendations targeting procedural, judicial, and ethical ambiguities that compromise the consistency and fairness of the IVC process across North Carolina. This theme indicated the participants' recommendations related to the IVC process. The theme emerged from grouping two categories. Table 7 lists the categories that were grouped to form this theme, along with the initial codes that were used to create these categories.

Table 7*Theme 6 Categories and Codes*

Theme	Category	Code	No. of text segments assigned	%
More training for magistrates, more clarity in IVC policy, and more choice in facilities were recommended.	IVC policy recommendations		15	12
			9	7
		Choice in facility would benefit patients.	5	4
		Clarity regarding substance abuse IVC	3	2
	Judicial recommendations	More specificity needed in criteria of imminent harm	1	1
			6	5
		Barriers to access for petitioning	1	1
		More consistent training of magistrates	5	4

Note. IVC = involuntary commitment.

Category: IVC Policy Recommendations. This category comprised data from nine participants, formed by grouping three related initial codes. The first code, choice in facility would benefit patients, included data from five participants. The finding indicated that the contributing participants recommended changing the policy that IVC patients must be sent to the first available facility in favor of giving more choice to the social worker making the determination and to the patient. P4 stated,

One of the policies that I hate is that you have to refer to all available psychiatric facilities, when you know some are better than others, and if they get taken to that

one psychiatric facility, then you know that they're gonna have better outcomes than if they go to another.

P4 believed that giving the social worker who made the IVC determination more choice in which facility a patient was committed to would benefit patients. P4 believed that patients should also have a choice and recommended, "Giving patients more choice when we can on where they go." The participants believed that giving social workers more choice in facilities would benefit the patient, and that giving the patient more choice would help to maintain some of the patient's right to self-determination.

Three participants recommended that policymakers provide more clarity regarding substance-abuse IVCs. P5 noted, "Something that has remained a really unclear, unanswerable aspect of first evaluations and commitments in general has absolutely been the use of substance use commitments. That is very much left up to the interpretation." P9 described some of the considerations involved in deciding whether IVC should be applied in situations of substance abuse:

Ethically, I'm not sure about that, as far as autonomy and self-determination. So, I think maybe the substance use part of that can impact the danger-to-self situation, if we have concerns about recent multiple overdoses, things like that, or doing dangerous things while intoxicated. I do think the substance use portion is maybe not in line with current research and what we know about substance use and recovery.

P9 noted that situations involving substance abuse raised concerns about autonomy (i.e., whether abusing substances was a reasonable exercise of self-determination), as well as

safety (e.g., the risk of overdose and of reckless behavior while intoxicated). In referring to the question of whether IVC policies were sufficiently consistent with current research, P9 raised the question of when, whether, and to what extent substance abuse should be considered voluntary, as opposed to a pattern of behavior compelled by physical addiction.

One participant recommended greater specificity regarding the criteria for determining a risk of imminent harm. P6 stated, “With imminent risk, there's never been an actual definition of what ‘imminent’ is. So, I think it could be fair to say having a little bit more specificity in the criteria could be helpful.” P6 believed that social workers would benefit from additional guidance from policymakers regarding the definition of “imminent.”

Category: Judicial Recommendations. This category comprised responses from six participants and was formed by grouping two related initial codes. The initial code identified barriers to access for petitioning, as noted in a response from one participant. P4 stated,

I do think that the general petitioning process can be challenging for people who are not familiar with the mental health system, and I think there are some barriers to access . . . Just depending on the county and the magistrate, [I recommend] more support for people in that initial petitioning process, to help them explain what this means, what they're getting into, what information they need to provide. What are realistic expectations of what comes after a petition? Yeah, it would be more useful for folks.

P4 indicated that some petitioners might face barriers to access due to a lack of understanding about the petition process, and P4 recommended offering guidance to petitioners to address this barrier.

Five participants recommended more consistent training for magistrates to ensure that they evaluated IVC petitions according to a consistent set of standards. P8 said in reference to this recommendation, “If everyone in their office (magistrate) was held to the same standard in reference to the knowledge they had and how they approved things that way across the board, it wouldn't be such a nuisance when creating IVC.” P7 recommended addressing inconsistencies across counties: “The local magistrate, maybe them having a better understanding of involuntary commitments and the criteria. I feel like a lot of the times, some counties are a lot more relaxed than others.” The participants believed that greater consistency across magistrates would make the IVC process more predictable and dependable.

In my practice, I saw the magistrate approve a petition for a child that only said, “Does not listen or do what she is told.” This situation does not demonstrate mental health concerns or harm to self or others and is a waste of first evaluator and hospital resources. Because of examples like this, I believe that more training for magistrates could be beneficial when they are approving community petitions. More clarity in the policy, especially regarding substance use IVCs, often arises in my work, along with discussions about how the policy does not always define some of the terms used in the criteria. Therefore, my experiences in my practice have inclined me to agree with the participants in this study that more clarity in policy and more training for magistrates are

needed. However, I remained mindful of my opinions during data collection and analysis to ensure that they did not distort my understanding of what the participants were saying.

Summary

Six RQs underpinned this study. RQ1 was the following: What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment? The findings indicated that assessment experiences involved assessing patient presentation, considering all relevant factors, and addressing patient needs. Other general experiences included an alignment between personal values and professional ethics, as well as the use of personal values to guide decision making within the broad parameters allowed to an IVC first evaluator.

RQ2 was the following: What ethical, legal, or administrative issues tend to compound this process? Ethical issues that complicated the IVC process included the need to prioritize professional ethics over personal sympathy or a desire to accommodate the patient, and the need to keep the patient informed, even when their knowledge of their rights might make the IVC process more difficult. Legal issues involved prioritizing the safety of the patient and others over the ethical obligation to uphold patient autonomy. This consideration could cause misgivings for participants who did not want to cause patients additional distress, but which could also resolve ethical conflicts between the obligation to ensure patient safety and the obligation to respect patient autonomy.

RQ3 was the following: What factors facilitate this decision-making process? The findings indicated that patient factors facilitating the IVC decision-making process

included risk and protective factors, as well as building rapport with the patient to gather information and initiate the process of mitigating resistance to treatment. Provider factors included the discouragement of IVC in some facilities and provider experience, which furnished a standard of comparison for assessing when patients were in crisis.

RQ4 was the following: What type of ethical conflicts surround this process and how are they resolved in the field? The findings indicated that external pressures on decision making could include pressure from family or medical providers, but that succumbing to these pressures was unethical if it went against the obligation to uphold patient safety and autonomy. The primary ethical conflict was between the obligation to protect the patient and others from harm and the obligation to respect the patient's autonomy. This conflict was always resolved in favor of safety if preserving the patient's autonomy involved a risk of imminent harm to the patient or others.

RQ5 was the following: What specific principles of biomedical ethics are present in the decision-making process? The findings indicated that the principles of beneficence and maleficence were central to IVC decision making. Beneficence was central because one of the purposes of IVC was to help the patient, and nonmaleficence was central because another purpose of IVC was to prevent harm to the patient and others. To the extent that patients might perceive IVC as harmful to them, the solution was to ensure that the patient's voice was heard and that the least restrictive treatment that would adequately mitigate the threat of harm was imposed.

RQ6 was the following: What recommendations do social workers have for needed policy changes that will facilitate the IVC process? The participants

recommended giving patients and social workers a choice in which facility receives an IVC patient, providing more clarity for substance abuse IVCs, and defining “imminent” in relation to imminent harm. The participants further recommended reducing barriers to access for IVC petitioners and training magistrates to apply IVC decision-making criteria consistently.

Section 4 includes discussion, interpretation, and recommendations based on these findings. Taken together, the findings from the six RQs reveal a complex interplay between clinical judgment, ethical imperatives, procedural ambiguity, and systemic limitations. The dominant themes across participant responses suggest that while social workers strive to uphold professional ethics, their capacity to do so is often constrained by inconsistencies in policy and judicial application. These findings underscore the urgent need for systemic reform that aligns policy clarity with the best ethical and clinical practices. Section 4 offers a critical synthesis of these findings, grounded in existing literature, and presents actionable recommendations for social work practice, policy reform, and future research directions.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The problem that motivated this study was that the decision-making process of social workers completing IVC first evaluations for inpatient psychiatric treatment had not been previously researched. This study addressed this problem by exploring how licensed social workers described their experiences when determining whether to place clients under IVC, while balancing legal and ethical responsibilities. A qualitative design was used, and individual, semistructured interviews were conducted with clinical social workers in North Carolina. I aimed for the resulting knowledge to enhance social workers' ability to make more ethical and informed decisions regarding IVC.

Summary of Findings

RQ1 asked the following: What is the general experience of the decision-making process for LCSWs in North Carolina when completing IVC first evaluations for inpatient psychiatric treatment? This question was answered by Theme 1, which was that experience included holistic assessments within ethical boundaries and ranked first in terms of frequency (31%). Specifically, assessment experiences involved evaluating patient presentation, assessing all relevant factors, and addressing patient needs. In addition, personal values aligned with professional ethics and were used to guide decision making within the broad parameters.

RQ2 asked the following: What ethical, legal, or administrative issues tend to compound this process? This question was addressed by Theme 2, which highlighted the importance of the code of ethics, respect for the patient, and ensuring safety in

compounded decision making, ranking fourth in terms of frequency (16%). Specifically, ethical issues included the need to prioritize professional ethics over personal sympathy or a desire to accommodate the patient, as well as to keep the patient informed, even when knowledge of their rights might make the IVC process more difficult. In addition, legal issues involved prioritizing the safety of the patient and others over the ethical obligation to uphold patient autonomy, which could cause patients additional distress but also resolve ethical conflicts between the obligation to ensure patient safety and the obligation to respect patient autonomy.

RQ3 asked the following: What factors facilitate this decision-making process?

This question was addressed by Theme 3, which highlighted the importance of experience, knowledge of the patient, and assessment of risk and protective factors in facilitating decision making, ranking third in terms of frequency (17%). Specifically, patient factors included building a relationship with the patient to gather information and mitigate resistance to treatment. In addition, provider factors included the discouragement of IVC in some facilities and the provider's experience, which offered a standard of comparison for assessing when patients were in crisis.

RQ4 asked the following: What type of ethical conflicts surround this process and how are they resolved in the field? This question was addressed by Theme 4, which stated that the protection of patient autonomy was balanced against the risk of imminent harm and ranked second in terms of frequency (24%). Specifically, external pressures could include those from family members or medical providers; however, succumbing to these pressures was unethical if it went against the obligation to uphold patient safety and

autonomy. In addition, the primary ethical conflict within IVC was between the obligation to protect the patient and others from harm and the obligation to respect the patient's autonomy, which was resolved in favor of safety if preserving the patient's autonomy involved a risk of harm to the patient or others.

RQ5 asked the following: What specific principles of biomedical ethics are present in the decision-making process, and how do they affect the decision-making process? This question was addressed by Theme 5, which emphasized that the principles of beneficence and non-maleficence were central to decision making. Specifically, beneficence was important because one of the purposes of IVC was to help the patient. In addition, nonmaleficence was important because it also served the purpose of preventing harm to the patient and others.

RQ6 asked the following: What recommendations do social workers have for needed policy changes that will facilitate the IVC process? This question was addressed by Theme 6, which recommended more training for magistrates, greater clarity in policy, and more choice in facilities, ranking fifth in terms of frequency (12%). Specifically, it was recommended to give patients and social workers a choice in which facility to use, provide more clarity for substance abuse cases, and define "imminent harm." In addition, it was recommended to reduce barriers to access for petitioners and train magistrates to apply decision-making criteria consistently.

These six findings reveal a complicated relationship between clinical judgment, ethical imperatives, procedural ambiguity, and systemic limitations within IVC. Furthermore, although social workers strive to uphold professional ethics, their capacity

to do so is often limited by inconsistencies in policy and judicial application. Thus, these results highlight the need for systemic reform that aligns policy clarity with ethical and clinical best practices.

The Findings in Relationship to the Literature

Theme 1: Holistic Assessments Within Ethical Boundaries

Part of Theme 1 involved assessing patient experiences, including evaluating patient presentations, considering all relevant factors, and meeting patient needs. Specifically, experiences of conducting IVC assessments involved assessing how patients presented to infer their mental state and any risk they might pose to themselves or others. In addition, although primary considerations were considered when evaluating, all relevant factors were also considered. Social workers also tried to evaluate a way that would meet the patient's needs. However, the North Carolina statute contains vague criteria for assessing an individual's dangerousness, with terms such as "being dangerous in the relevant past" not being fully defined (Treatment Advocacy Center, 2018). Furthermore, there are differences between states regarding the definition of dangerousness, with some states requiring proof of threat and others only requiring predicted threat (Gordon, 2016). Thus, the IVC process can be complex.

Another part of Theme 1 was experiences of value alignment, including working within the first evaluator parameters. Specifically, these parameters were broad, so social workers' own values and standards guided their IVC decision making. Similarly, rather than using structured decision making, social workers often justify their decisions based on their experiences, values, research, or client preferences (Taylor, 2017). In addition,

clinicians tend to rely on their values/beliefs, experiences, knowledge, and ability to empathize with their clients' situations when making decisions (McLaughlin et al., 2010). Therefore, the IVC process can vary depending on the social worker.

Theme 2: Code of Ethics, Respect for the Patient, and Safety Measures as Factors Compounding Decision Making

Part of Theme 2 focused on ethical issues, including the code of ethics and safety. In other words, the code of ethics and safety were compounding factors in the evaluation process. To illustrate, there are potential issues with the code of ethics in cases of seclusion, which is similar to IVC, because both are justified on the grounds of safety. However, autonomy is not violated because patients lack the capacity to make decisions; justice, beneficence, and nonmaleficence can still be compromised (Zheng et al., 2019). In addition, there is a connection between the code of ethics and IVC in terms of autonomy/self-determination and beneficence, as a patient may lack a desire for treatment while also meeting legal criteria (Kendall & Hugman, 2016). Thus, this process can be morally taxing. Ethics are further discussed in this section.

Another part of Theme 2 was legal issues, including consideration of immediate risk and ensuring patient safety. Specifically, the obligation to consider the risk of imminent harm to the patient or others sometimes conflicted with the desire to spare the patient from additional distress. In addition, while the obligation to keep patients safe sometimes conflicted with the obligation to uphold patient autonomy, the priority given to considerations of safety enabled participants to feel that preventing a patient from harming themselves or others was a success despite the deprivation of autonomy. As a

result, clinicians may suggest IVC for patients who do not fully meet the legal criteria solely because they feel that the patient could benefit from it (Appelbaum, 1992).

Furthermore, clinicians may be unaware of IVC criteria, leading to varied understandings, interpretations, and implementations (Shdaimah & O'Reilly, 2016).

Therefore, this process can involve legal complications.

Theme 3: Experience, Knowledge of Patient, and Assessment of Risk and Protective Factors as Facilitators of Decision Making

Part of Theme 3 was patient factors, including evaluating risk and protective factors and mitigating patient resistance. Specifically, the patient-specific considerations of assessment of risk and protective factors and the ability to mitigate patient resistance through relationship-building facilitated decision making. As for the former, “dangerousness” means that there must be evidence that an individual poses a danger to themselves or others to qualify for IVC; however, there are different interpretations of this standard among legal experts and mental health professionals (Garland, 2022). As for the latter, patients subjected to IVC can struggle with autonomy and self-determination due to the removal of personal decision making involved in the process (Shdaimah & O'Reilly, 2016). Thus, this process can be difficult for the patient.

Another part of Theme 3 was provider factors, including aiming to keep IVC rates down and experience as an advantage. Specifically, the provider-based elements of external pressure to reduce IVC rates and accumulated clinical experience, which provided a broader context for evaluating patients, influenced IVC decisions. To illustrate, the rates of IVC have increased significantly, more than the mean state

population increase (Lee & Cohen, 2021). Additionally, individual differences in how clinicians assess risk, as well as the role of instinct based on experience, as opposed to structured best practice methods, influence mental health decision making (Fistein et al., 2016). Therefore, this process can be difficult for the social worker.

Theme 4: Protection of Patient Autonomy Balanced Against Risk of Imminent Harm

Part of Theme 4 was external considerations, including pressure from family members and medical providers. In other words, there were outside influences on IVC decision making. Furthermore, providers are expected to understand the power inequality between themselves and their patients and how it impacts IVC (Brodwin, 2014). In addition, the pillar of decision-making dilemmas is power conflicts, and shifting IVC models to be more person and family-centered requires attention to how that power is utilized (Hui et al., 2020). Thus, this process can also include those not directly involved.

Another part of Theme 4 was patient-centered considerations, including patient autonomy, self-determination, and the potential for imminent harm. Specifically, there was a need to balance the obligation to respect the patient's autonomy against the obligation to ensure the patient's safety and the safety of others. Similarly, there can be conflict between the role of the social worker as an advocate and their participation in the IVC process, which aims to protect both the patient and society from harm, potentially causing distress (Wu et al., 2013). Furthermore, a consequence of IVC is that individuals may form untrusting relationships with providers, resulting in them being less likely to disclose suicidal ideation in the future and more likely to encourage others to avoid

psychiatric hospitalization (Jones, Gius, Shields, Collings, et al., 2021). Therefore, it can be hard to decide what is best for the patient.

Theme 5: Centrality of Principles of Beneficence and Nonmaleficence to Decision Making

Theme 5 was that the biomedical ethics principles of beneficence and nonmaleficence were central to IVC decision making. However, despite the correlation between mental illness and poor physical health, these two fields have missed opportunities to collaborate when navigating through challenges involving the rights of patients, providers, and society within IVC (A. R. Williams, 2016). For example, within social work practice, the concepts of advocacy and justice are frequently used in conjunction when discussing human rights (Steen, 2018). I also discuss ethical aspects in this section.

Theme 6: Recommendations for More Training for Magistrates, Clarity in IVC Policy, and Choice in Facilities

Part of Theme 6 included policy recommendations, such as choice of facility, clarity regarding substance abuse, and specificity in the criteria for imminent harm. Specifically, it was suggested to change the policy from sending IVC patients to the first available facility to giving the social worker and patient more choice. On the other hand, North Carolina and many other states utilize correctional facilities and hospital emergency departments to treat those struggling with mental illness due to a deficit in psychiatric beds (Fuller et al., 2016). In addition, it was suggested that policymakers provide more details on substance abuse. For example, clinicians evaluating IVC for

substance use disorders may consider a wide range of behaviors to establish imminent risk and may endorse commitment without satisfying statutory criteria (Christopher et al., 2021). It was also suggested that policymakers provide additional guidance on the definition of “imminent.” For instance, some psychiatrists interpret dangerousness criteria as requiring an individual to pose an immediate danger to themselves or others. In contrast, others interpret the criteria as requiring the individual’s circumstance to present a probable danger (Gordon, 2016). Therefore, policy issues require attention.

Another part of Theme 6 was judicial recommendations, including addressing barriers to access for petitioning and providing more consistent training for magistrates. Specifically, there were obstacles associated with not understanding how the IVC petition process worked, and it was suggested that guidance be offered to petitioners. Additionally, it was suggested that there be more standardized training for magistrates to ensure they consistently evaluate IVC petitions. To illustrate, there may be a misalignment between clinical and legal interpretations of petitions and how those without this specific training may interpret them (General Assembly of North Carolina, 2018). Furthermore, a magistrate only needs to have reasonable grounds to believe the petitioner before issuing a custody order to law enforcement (General Assembly of North Carolina, 2018). Therefore, judicial issues require attention.

The Findings in Relationship to Theory

Two codes of ethics were important to this study. The first was the NASW (2021) *Code of Ethics*, as discussed further in this section. However, research has argued that the code is too specific in some areas yet too vague in others while also containing

contradictions (Pugh, 2017). In response, social work has been connected to a second code, biomedical ethics, which includes the principles of autonomy (i.e., respecting the decision-making abilities of individuals), nonmaleficence (i.e., avoiding the causation of harm), beneficence (i.e., providing benefits and balancing them with burdens and risks), and justice (i.e., fairness in the distribution of benefits and risks; Beauchamp & Childress, 1994). Still, there remains conflict because what the individual wants for themselves can also cause harm (Sasson, 2000). Furthermore, there is conflict between the principle that coercion is a violation of fundamental rights and the belief that it may be beneficial to the patient (Abbott, 2021; Morandi et al., 2021). Thus, although each has disadvantages, these two codes of ethics should be combined to apply their advantages within the context of IVC.

Biomedical ethics related to Theme 5 of this study, which was that its principles of beneficence and nonmaleficence were central to decision making. If patients perceived IVC as harmful to them, the solution was to ensure that the patient's voice was heard and to impose the least restrictive treatment that would adequately mitigate the threat of harm. Therefore, social workers need to carefully address conflict within this complex process.

Application to Professional Ethics in Social Work Practice

The NASW (2021) *Code of Ethics* includes the values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Social workers are expected to help people in need and address social problems, challenge social injustice, respect the inherent dignity and worth of the person, recognize the central importance of human relationships, behave in a trustworthy manner,

and practice within their areas of competence and develop and enhance their professional expertise (NASW, 2021). There are also standards concerning social workers' ethical responsibilities to clients, to colleagues, in practice settings, as professionals, to the profession, and to society (NASW, 2021).

The two values of service and dignity and worth of the person are relevant to three findings from this study. The first was experiences of value alignment within IVC, including personal values aligned with professional ethics, which was part of Theme 1. There was an overlap between participants' professional obligation to ensure that patients who needed help received it and their personal commitment to helping those in need. This finding relates to the principle that social workers help people in need and address social problems.

The second relevant finding was ethical issues, including keeping the patient informed, which was part of Theme 2. The ethical obligation to keep the patient informed was a compounding factor as informing patients of their rights gave them the opportunity to resist IVC. This finding relates to the principle that social workers respect the inherent dignity and worth of the person. The third relevant finding was the ethical conflict between protecting patient autonomy and the risk of imminent harm, which was part of Theme 4. There was a need to balance the obligation to respect the patient's autonomy against the obligation to ensure the safety of the patient and others within IVC. This finding relates to both principles, indicating tension between the two.

Overall, a primary focus of social workers' ethical responsibilities was respecting clients' self-determination, along with protecting the rights of clients who could not make

their own decisions. However, a problem arises when social workers participate in this process because it removes autonomy from clients in a possibly unethical manner. In addition, although there is an opportunity for IVC and legal systems to work in harmony, there can be situations where mental health professionals seek treatment for individuals who do not meet full legal criteria. Ultimately, this study supported the NASW (2021) *Code of Ethics* by highlighting areas in which it existed and could be applied to ensure social justice for clients.

Recommendations for Social Work Practice

Based on the findings from this study, specifically Theme 6, social workers recommend policy and judicial changes to facilitate the IVC process. Policy recommendations include choice of facility, clarity regarding substance abuse, and specificity in the criteria for imminent harm. They are based on the issues of patients being sent to the first available facility due to a shortage of psychiatric beds (Fuller et al., 2016), clinicians having inconsistent views on what justifies IVC in cases of substance abuse (Christopher et al., 2021), and psychiatrists having different definitions of what makes a patient dangerous (Gordon, 2016). Judicial recommendations include addressing barriers to access for petitioning and providing more consistent training for magistrates. They are based on the issues of petitioners not having the knowledge needed to understand the process, as well as magistrates evaluating petitions subjectively (General Assembly of North Carolina, 2018). Overall, social workers recommend more guidance for petitioners, more training for magistrates, more clarity in policy, and more choice in facilities to improve IVC.

These changes can be implemented through the following action steps:

1. Petitioners for IVC should receive more guidance to help them better understand the petition process. This goal can be achieved through providing them with a document that has all the information they need. More knowledgeable petitioners would make this process run more smoothly.
2. Magistrates should receive more standardized training so that they evaluate IVC petitions more objectively. This goal can be achieved through developing a course on how to successfully navigate this process. Greater consistency across magistrates would increase their dependability.
3. Substance abuse and imminent harm should be more clearly defined in IVC guidelines. This goal can be achieved through updating regulations to specify what these terms mean. Social workers would benefit from additional information on how to best approach these cases.
4. Social workers and IVC patients should have more choice in facilities rather than simply being assigned to whichever is first available. This goal can be achieved through allowing them to pick the most appropriate option. Such authority would maintain patients' self-determination.

There are also several prerequisites for these objectives. First, those who wish to petition for IVC need to be informed of the criteria before starting the process to ensure that it is the most appropriate course of action. This exchange should be led by social workers as they are the experts in this case. Second, relevant organizations (e.g., legal and educational) need to collaborate in order to create and enforce a standardized training

program on the evaluation of IVC petitions by magistrates. This course should be tested to ensure effectiveness and then be made a requirement to complete before becoming a magistrate. Third, policymakers need to determine how to thoroughly explain IVC in terms of substance abuse, imminent harm, and petitioning to social workers. These policies should be distributed to all social workers so that they are aware of the changes. Fourth, the shortage of psychiatric beds needs to be addressed by expanding current facilities and building new facilities in order for patients to have a choice. This initiative should be justified to the government using data from studies such as this one so that they will fund it. Thus, there is much work that needs to be done to improve IVC.

Usefulness and Limitations

This study is useful because it fills a knowledge gap on the experiences of social workers in North Carolina with the decision-making process for IVC first evaluations. Social workers' involvement in this process is relatively new in North Carolina and has not been empirically studied until now. Furthermore, the process in general is complex and debated (McLaughlin et al., 2010). First evaluators have the complicated role of determining if a client's presentation is severe enough for them to be held against their will (Henwood, 2008), and social workers experience conflict as they generally view coercion as a violation of patients' rights while agreeing that it may be beneficial and unavoidable in the context of psychiatry (Abbott, 2021; Morandi et al., 2021). I hope that this study's investigation of this gap will lead to updated policies that ensure that IVCs are appropriate for individual patients.

The research design of this study was also well-suited to explore this topic. A qualitative methodology offers a robust and flexible approach for studies involving individuals' subjective perceptions (Alam & Asmawi, 2024). Specifically, this methodology allows for capturing the depth and complexity of participants' responses and addressing important questions without being confined to specifics (Alam & Asmawi, 2024; Patton, 2015). Furthermore, the methodology is appropriate for exploring the multifaceted influences on social workers' decision making as it provides a framework for examining the detailed and nuanced experiences of those in this field (Darlington & Scott, 2020). In addition, to address bias, the researcher relied on member checking (i.e., participants being able to review their responses) and reflexivity (i.e., keeping a journal to reflect on personal reactions and emotions in relation to social judgments and beliefs). Therefore, the qualitative methodology was the best option for this study.

However, despite its advantages, this study had multiple limitations. First, despite methods to reduce it, researcher bias still might have influenced this study, impacting the trustworthiness of its findings (Ravitch & Carl, 2021). Because I was a social worker and the researcher focused on this field, my questions might not have been neutral due to personal involvement in the topic. In addition, participant bias might have impacted the trustworthiness of the findings. The participants were also social workers, so their responses might not have been neutral. In other words, both the participants and I might have asked/answered questions in a biased manner because the results of this study might affect their jobs as social workers.

Second, the small sample size typical of qualitative research limited the generalizability of the findings (Hennink & Kaiser, 2022; McDermott, 2023). Because in-depth interviews were conducted, the number of participants was restricted to ensure that data were collected and analyzed in a timely manner, meaning that they might not have been representative of the broader population. Furthermore, the narrow focus on North Carolina also might have limited the generalizability of the findings. IVC in this state might have differed from that in other states, so the results might not be transferable to other contexts. In other words, both the small number of participants and the specific setting might cause the results to not be applicable to social work and IVC in general.

Future Research

To address the limitations, further research can be conducted to produce results that are more trustworthy and generalizable. For example, future studies can reduce bias by including non-social worker researchers and participants, as well as broaden their scope by increasing the number of participants and locations. To do so, further research can consider the following recommendations:

1. Studies with less biased researchers and participants can be conducted to allow for more trustworthy results. They can include people outside of social work so that personal involvement in the field of study does not influence the data. For example, they can be knowledgeable about IVC but indirectly involved.
2. Since patient autonomy was a large part of this study, studies can be conducted with patients and their families to obtain their viewpoints on their

experiences with IVC. Demographic data of social workers and patients can also be collected to determine the impact of such characteristics on outcomes.

3. Quantitative studies with large sample sizes can also be conducted to allow for results that are more generalizable. They can include many more participants so that they are more representative of the broader population. For example, closed-ended surveys can be used to collect extensive numerical data.
4. Because this study was set in North Carolina, studies could be conducted in other states to allow for cross-state comparisons of intervention effectiveness and best practices in ethics and client services. IVC training and execution can also be evaluated to determine areas for improvement.

Future researchers may collect various types of data, which will allow for data triangulation. For example, it will be helpful to receive feedback from patients and their families regarding the quality of IVC placement decisions and their expectations about the implemented processes and policies. Moreover, independent professionals and/or appointed ethical boards may be called in to evaluate these decisions and provide their evaluations and recommendations. Another source of data regarding this matter may be court decisions in cases in which the rights of patients were found to be violated. All these different types of data taken together may help enlighten further best practices in IVC placement decision making.

Dissemination

I will disseminate the recommendations for IVC action and research in various ways. First, the recommendations will be shared both physically and digitally in North

Carolina and other applicable states to allow for reaching as many people as possible. For example, I will prepare an executive summary of this study and send it to organizations, such as the North Carolina Department of Health and Human Services, which oversees the IVC process in this state, and the equivalent in other states.

Second, these recommendations will be shared with all IVC stakeholders. Relevant recipients of the aforementioned documents include policymakers, social workers, and researchers as they have influence in this context. In addition, social workers will be encouraged to share this information with their patients at the beginning of the IVC process to increase their self-determination. I will also seek to publish the findings of this study in professional journals in the field, as well as present them at professional conferences. This method will allow different parties to work together to improve the process from all angles.

Implications for Social Change

This study can positively impact social change in various relevant fields. At the policy level, it is recommended to update IVC regulations to achieve greater standardization, increased clarity, and enhanced choice, thereby improving outcomes. At the practice level, information is provided on how to effectively implement such policies, such as through improved training of social workers. At the research level, the dearth of knowledge regarding the relatively new involvement of social workers in the IVC process in North Carolina is addressed (Senate Bill 437 [Public] General Assembly of North Carolina Session, 2011), and directions for further research to enhance the trustworthiness and generalizability of the study's findings are provided, including

strategies to reduce bias and expand the study's reach. Put simply, this study can improve policy, practice, and research in terms of IVC.

This study can also have a positive impact on social change for various relevant parties. At the macro-level, policymakers are informed on how to better serve social workers by increasing clarity and consistency (Gordon, 2016; Kaufman & Way, 2010; Shdaimah & O'Reilly, 2016). At the meso-level, social workers are informed on how to better serve their patients by balancing autonomy and safety (Kendall & Hugman, 2016; Shdaimah & O'Reilly, 2016; Walton & Hall, 2017). At the micro level, patients are informed of the advantages and disadvantages of IVC to enhance their self-determination (Goldman, 2015; Jones et al., 2021a; Jones et al., 2021b). In other words, improved regulations can lead to more effective social workers, which in turn can result in more satisfied patients.

Overall, this study can enhance social workers' ability to make more ethical and sound decisions regarding IVC. Specifically, it provides insight into the conflict between viewing coercion as a violation of rights yet agreeing that it may nevertheless be helpful to patients and unavoidable in the context of psychiatry (Abbott, 2021; Morandi et al., 2021). Additionally, it can lead to the development of updated policies and practices, as the experiences of social workers can reveal ways to enhance their decision making (Morandi et al., 2021). Consequently, the findings can be used to improve the field of social work in the context of IVC.

Importantly, this study can benefit not only individuals but also society at large. This objective is consistent with the NASW (2021) Code of Ethics, which states that

social workers have ethical responsibilities to both clients and broader society. Clients' interests are generally of primary importance, but social workers' responsibilities to society or legal obligations may occasionally supersede loyalty to clients, and clients should be advised of the latter (e.g., when a social worker is required by law to report that a client has threatened to harm themselves or others; NASW, 2021). Furthermore, the moral principle of individual autonomy may sometimes be overridden by moral considerations of safety for the individual or society (Beauchamp & Childress, 2019). Specific social responsibilities include social welfare (i.e., development of people, communities, and environments), public participation (i.e., informed involvement in shaping social policies and institutions), public emergencies (i.e., appropriate professional services to the greatest extent possible), and social and political action (i.e., equal access to resources, choice and opportunity for all, respect for cultural and social diversity, and prevention of inequality; NASW, 2021). Therefore, social workers must consider society in addition to individuals.

Promoting social justice at the individual level may in turn benefit society as patients may become more productive and less stigmatized and invest in the betterment of not only themselves but also their communities. The World Health Organization (WHO, 2022) supports this argument by stating that investing in mental health can reduce suffering and improve the physical health, quality of life, functioning, and life expectancy of those who are mentally ill. In addition, anti-stigma interventions, especially social contact strategies where people with lived experience help to shift attitudes, can reduce discrimination in the community (WHO, 2022). Ultimately, when people are mentally

healthy and live in supportive environments, they can contribute to communities, which would benefit everyone (WHO, 2022). Thus, improving IVC can better help patients, which can also improve society as a result.

Summary

In summary, I examined the complex decision-making process of social workers conducting initial evaluations for IVC in North Carolina, a relatively new and understudied phenomenon. Interviews were conducted with such social workers, and the resulting qualitative data were analyzed to determine common themes. The findings were that (a) experiences included holistic assessments within ethical boundaries; (b) the code of ethics, respect for the patient, and ensuring safety compounded decision making; (c) experience, knowledge of the patient, and assessment of risk and protective factors facilitated decision making; (d) protection of patient autonomy was balanced against risk of imminent harm; (e) the principles of beneficence and nonmaleficence were central to decision making; and (f) more training for magistrates, more clarity in policy, and more choice in facilities were recommended. The first five findings provide much-needed information on this complicated process, and the last finding leads to action steps to improve social work and IVC.

This study is useful as it addresses a knowledge gap on social workers' experiences with IVC in North Carolina and suggests ways to enhance this process. However, its limitations included the potential for researcher and participant bias to have compromised the trustworthiness of the findings, as well as the small sample size and specific location, which might have restricted their generalizability. These limitations can

be addressed through further research, including studies that involve other types of researchers and participants to obtain a more comprehensive perspective, as well as the use of quantitative methods to reach a broader audience in multiple locations, which will increase confidence in the findings.

I will disseminate these recommendations for research, as well as those for action (e.g., increased training, clarity, and choice), through various channels to various stakeholders, with the goal of bringing about improvements to the IVC process in North Carolina and beyond. This study can positively impact social change in policy, practice, and research while informing the work of policymakers, social workers, and patients. Such a change can also benefit society at large, as improved policy and research can lead to more effective social workers, who can better assist patients, who can then contribute more positively to their communities.

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Appendix A: Site Permission Letter

Date

Research Site's Official Name

Research Site Name

Research Site Address

Dear [Research Site's Official Name],

I am working on a doctoral dissertation, entitled, "Exploring Decision-Making Experiences of Social Workers Completing Involuntary Commitment First Evaluations for Inpatient Psychiatric Treatment". My research will be overseen by my faculty mentor, [Mentor Name].

My research examines the decision-making process of social workers completing first evaluations for involuntary commitment (IVC). I will be recruiting licensed social workers who have experience with completing first evaluations for IVC to participate in my study.

I am requesting permission to conduct my dissertation research at [insert name of site].

Specifically, I am requesting permission to recruit study participants by sending a recruitment email to your members.

This project will begin once I have obtained approval from Walden University's Institutional Review Board (IRB), which will review my study to ensure the adequacy of my plan for protecting participants.

Any data collected will be kept confidential. In accordance with Walden policy and best practices for ethical research, neither participants nor sites will be identified in any report of my findings or in my published dissertation. I will provide a copy of the aggregate results from this study upon your request.

If you have any concerns about this request, please contact me at the phone number listed below.

Sincerely,

Jesse Creech

A solid black rectangular redaction box covering the signature area.

Appendix B: Recruitment Materials

Email Invitation

Subject Line: Interviewing licensed social workers about completing first evaluations for involuntary commitment (IVC) in North Carolina

Email Message

You are invited to share your views for a study titled: “Exploring Decision-Making Experiences of Social Workers Completing Involuntary Commitment First Evaluations for Inpatient Psychiatric Treatment”

- One 60-minute online interview that will be audiorecorded (no videorecording)
- To protect your privacy, the published study will not share any names or details that identify you

Interviews will take place during January-February 2025.

Volunteers must meet these requirements:

- Must be a licensed clinical social worker in North Carolina who has completed the certification process to become a first evaluator for IVC
- Have at least one year of experience of making such a decision

Please message Jesse Creech privately through [REDACTED] to let them know of your interest.

Social Media Post



**INTERVIEW
STUDY**

SEEKS

**LICENSED SOCIAL
WORKERS IN NORTH
CAROLINA**

LICENSED SOCIAL WORKERS MUST HAVE CURRENT CERTIFICATION AS
FIRST EVALUATOR FOR INVOLUNTARY COMMITMENTS

IF INTERESTED, PLEASE CONTACT:

[REDACTED]

The image is a recruitment poster for an interview study. It features a yellow and black color scheme. At the top, a yellow box contains the text 'INTERVIEW STUDY' in bold black letters. Below this, a black box contains the text 'SEEKS LICENSED SOCIAL WORKERS IN NORTH CAROLINA' in yellow letters. Underneath, there is a line of text in black: 'LICENSED SOCIAL WORKERS MUST HAVE CURRENT CERTIFICATION AS FIRST EVALUATOR FOR INVOLUNTARY COMMITMENTS'. Below that, it says 'IF INTERESTED, PLEASE CONTACT:' followed by a black redaction box. At the bottom, there is an illustration of a woman and a man sitting in yellow armchairs, facing each other in conversation. The background is a light beige color with decorative circular patterns.

Caption: You are invited to share your views for a study titled: “Exploring Decision-Making Experiences of Social Workers Completing Involuntary Commitment First Evaluations for Inpatient Psychiatric Treatment”

- One 60-minute online interview that will be audiorecorded (no videorecording)
- To protect your privacy, the published study will not share any names or details that identify you

Interviews will take place during January-February 2025.

Volunteers must meet these requirements:

- Have at least one year of experience of making such a decision

Please message Jesse Creech privately through [REDACTED] to let them know of your interest.

Appendix C: Participant Interview Guide and Questions

For this capstone study, the central research question asks, "What is the experience of the decision-making process for licensed clinical social workers in North Carolina when completing first evaluations for involuntary commitment for inpatient psychiatric treatment?" Conducting research would answer this question by gathering data from North Carolina social workers certified as first evaluators. To answer the central question, utilizing the interview guide questions below related to the decision-making process is essential. The guide also includes potential follow-up questions.

Interview Guide

Participant ID#:

Interview Method: Zoom, FaceTime Phone Call, or in-person interview.

Date of Interview:

Time and Length of Interview:

Age:

Gender Identity:

Racial/Cultural Background:

Interview Guide Questions

1. How did you become aware of North Carolina allowing Licensed Clinical Social Workers to complete certification to become first evaluators?
2. What made you decide to complete this certification?
 - a. How long have you been certified, and have you completed a renewal?
 - b. If yes – What motivated you to continue this certification?

i. (Personal attitudes and values towards IVC)

3. How do you define success in your work as a Licensed Clinical Social Work?
(Young, 2015) (RQ1)
 - a. How do you define success in your work as a first evaluator for IVC petitions?
4. "This question is intended to explore how your personal values and beliefs may play a role in your professional judgment when evaluating whether involuntary commitment to inpatient treatment is appropriate. Your reflections on this process are valuable to understand the complexities involved in these decisions. Please know that your responses will be kept confidential, and the goal is to understand your decision-making process in a professional capacity."

When completing a first evaluation for involuntary commitment to inpatient treatment, can you describe your decision-making process? (McLaughlin et al., 2010)
(RQ1, RQ2)

- a. How do you feel your professional work experience impacts your decision-making process? (Also mentioned in Taylor and Whittaker (2018)).
- b. How do you feel your professional values and beliefs impact your decision-making process?
- c. In your professional role, how do you feel your personal values and beliefs influence your decision-making process? Please reflect on how these values shape your approach to situations you encounter in your work.
- d. How do you feel your understanding of the client/patient impacts your decision-making process?

- e. Is there anything that you feel makes this process difficult?
5. Can you describe your understanding of the social work code of ethics concerning autonomy, self-determination, and justice? (RQ2, RQ4)
 - a. How does each piece of our code of ethics play a role in your decision-making process as a first evaluator?
6. How do you navigate the ethical tension between ensuring safety and respecting autonomy in your decision-making process? (Beauchamp and Childress, 2019). (RQ2, RQ4)
7. Considering the principles of beneficence - the act of helping others and Nonmaleficence - doing no harm, do you feel these impact your decision-making process? (RQ4, RQ5)
 - a. How so?
8. Are there any other internal or external pressures that influence your decision-making process? (RQ2, RQ4, RQ5)
9. What are some of the most significant factors impacting your decision-making process for first evaluations for involuntary inpatient commitment? (Fistein et al. 2016). (RQ1, RQ3)
10. How do policies surrounding the process impact your decision making? (RQ2, RQ6)
11. Are there any aspects of the IVC process that you believe could be improved or changed to better support your work as a first evaluator? (RQ6)

Appendix D: Codebook

Theme	Category	Initial code	No. of participants	No. of recurrences
Theme 1. Experience included evaluating all relevant factors and working within first evaluator ethical parameters			12	38
	Category. Assessment experiences		12	28
		Assessing patient presentation	6	7
		Evaluating all relevant factors	10	13
		Meeting patient needs	8	8
	Category. Experiences of value alignment		9	10
		Personal values aligned with professional ethics	7	7
Theme 2. Code of ethics, respect for the patient, and ensuring safety compounded decision-making		Working within first evaluator parameters	3	3
			12	19
	Category. Ethical issues		8	10
		Focusing on code of ethics and safety	7	7
		Keeping patient informed	3	3
	Category. Legal issues		8	9
		Consideration of immediate risk	3	3
Theme 3. Experience, knowledge of patient, and assessment of risk and protective factors facilitated decision-making		Ensuring patient safety	6	6
			10	20
	Category. Patient factors		7	10
		Evaluating risk and protective factors	4	4
		Mitigating patient resistance	5	6

Theme	Category	Initial code	No. of participants	No. of recurrences
Theme 4. Protection of patient autonomy was balanced against risk of imminent harm	Category. Provider factors		8	10
		Aiming to keep IVC rates down	2	2
		Experience as an advantage	7	8
			12	29
	Category. External considerations		8	9
		Pressure from family members	1	1
		Pressure from providers	8	8
	Category. Patient-centered considerations		11	20
		Patient autonomy and self-determination	10	14
		Potential for imminent harm	6	6
Theme 5. Principles of beneficence and nonmaleficence were central to decision-making			9	12
		Beneficence and nonmaleficence central to decision-making	9	12
			11	15
Theme 6. More training for magistrates, more clarity in criteria, and more choice in facilities were recommended	Category. IVC policy recommendations		6	9
		Choice in facility would benefit patients	4	5
		Clarity regarding substance abuse IVC	3	3
		More specificity needed in criteria of imminent harm	1	1
	Category. Judicial recommendations		6	6
		Barriers to access for petitioning	1	1
		More consistent training of magistrates	5	5