Title: The Structuration of Community-Based Mental Healthcare: A Duality Analysis of a Volunteer Group's Local Agency

Corresponding Author:
Alaina C. Zanin Ph. D.
Arizona State University[1]
Stauffer, 434A
Tempe, AZ
E: alaina.zanin@asu.edu
C: 1-405-334-7142

Co-Author:
Cameron W. Piercy Ph. D.
University of Kansas[2]
1440 Jayhawk Blvd., Room 102
Lawrence, KS 66045
E: cpiercy@ku.edu
C: 1-580-560-6610

[1]Data collection was conducted while both authors were employed at the University of Central Missouri with permission from the University's Internal Review Board. Arizona State University is the present address of the first author. [2]The University of Kansas is the present address of the second author.

Abstract

Using a lens of structuration theory, this study highlights the ways that specific structures within the current community-based model of mental healthcare might enable and constrain individuals and families living mental illness. Through a case study of a volunteer mental illness advocacy group, the authors employed a *duality analysis* on a variety of data collected from the case (i.e., interviews, organizational documents, and community healthcare data). Findings indicate that while group members encountered structural barriers to their organizational mission, they also used communicative agency creatively and collectively to (re)create structures within the current community-based model of mental healthcare. Member agency is examined in relation to perceived structural influence. Theoretical and practical applications of the findings are discussed.

Keywords: Mental health, structuration, agency, duality analysis, volunteer organization

The Structuration of Community-Based Mental Healthcare:
A Duality Analysis of a Volunteer Group's Local Agency

According to a recent national survey conducted by the National Institute of Health (NIH), an estimated 43.5 million adults in the United States self-identified as living with a mental illness (MI) in 2015 (NIH, 2015). While mental illness is pervasive in the U.S., systematic coordinated support and care for the mentally ill is not. Within the last 50 years the mental health care system in the U.S. has shifted from a long-stay institutional model to a fragmented community-based mental health service model (Fakhoury & Priebe, 2007). A number of factors including changing public opinion, new civil rights legislation, the use of pharmaceutical drugs therapy, and expansions of federal Medicaid and Medicare programs influenced this shift (Krieg, 2001).

The deinstitutionalization movement has yielded positive outcomes for some patients including increased care quality, autonomy, and the protection of civil and human rights (Rothbard & Kuno, 2000). However, state-run psychiatric hospital closures left a mental healthcare void in many communities that the new community-based care model struggles to fill. Currently, many state community-based models remain fragmented, complex, and underfunded (Perry, 2016). Research has demonstrated that this gap in care and coordination has yielded unintended negative consequences for the mental illness community, including higher proportions of homelessness and incarceration among the mentally ill (Henry, Shivji, deSousa, & Cohen, 2015; Steadman, Osher, Robbins, Case, & Samuels, 2009).

Given that almost one in five (i.e. 18 percent) all American adults must manage the emotional and financial stresses associated with mental illness, many individuals and families affected turn to non-profit groups for support (Tsang, Tam, Chan, & Chang, 2003). These groups offer a variety of services to local communities that include: providing education, advocating for policy, connecting disparate resources, and holding support groups. Similar to other volunteer

organizations, mental illness advocacy groups encounter many barriers to supporting members including health law complexity, limited resources, and uncoordinated stakeholder groups (Lewis, 2014). These barriers are compounded by stigma associated with mental illness (Cabassa, Siantz, Nicasio, Guarnaccia, & Lewis-Fernández, 2014; Link, Mirotznik, & Cullen, 1991).

Previous scholarship has investigated practitioners, patients, and family's experiences within the model of community based mental healthcare (Lefley, 1996). Research on the success of mental health interventions in schools and for-profit organizations has yielded promising results in terms of positive rehabilitation outcomes for patients (Jane-Llopis et al., 2011). Yet, many individuals with mental illness and their families still struggle to obtain access to healthcare interventions (Nakash, Cohen & Nagar, 2018). Non-profit organizations may provide the missing network connection to facilitate access for individuals living with mental illness in this new system of care; however, more research needs to be done about the role these advocacy groups fill in a complex, often dysfunctional system.

Structuration theory is a useful lens to document healthcare issues as they manifest in daily discourse (e.g., Carmack, 2010b; Olufowote, 2008). For example, Olufowote's (2008; 2009) work on informed consent laws demonstrated how socio-historical and litigation movements manifested in physician discourse in unexpected and unintended ways. Here, discourse is defined as ways of talking and therefore ways of thinking in a given context (see Alvesson & Kärreman, 2000). These structurational studies focus on bridging the problematic micro-macro discourse dichotomy in past organizational studies (Conrad & Haynes, 2001) to document the complexities of healthcare contexts. Structuration-based health research suggests how actors within healthcare contexts might reproduce more effective and functional structures. Therefore, the purpose of this

study is to understand how one volunteer advocacy group was constrained and enabled by the current model of community based mental healthcare. The following sections review basic premises of structuration theory in relation to the current model of mental healthcare in the U.S.

Review of Relevant Literature

Structuration Theory: Exploring Dualities to Understand Complexity

Structuration is one of the central theories in organizational communication, organizational science, and social science *writ large* (Conrad & Haynes, 2001; Richter, 2000). In relation to community-based mental healthcare, structuration theory (Giddens, 1979; 1984) serves as a valuable framework to understand volunteer member's interactions. Giddens contends that the production and reproduction of social environments through rules and resources constitutes the totality of human interaction. Specifically, through the use of rules and resources humans call on past experience and personal ability (i.e., agency) to (re)produce social structure. *Structures* are the rules and resources that enable and constrain decision, choice, action, and thought. At the same time, *agency* is the ability of an individual to take action. Together structure and agency form a duality. The *duality of structure* is such that structures are both the medium and the outcome of action: "They are the medium of action because members draw on structures to interact. They are its outcome because rules and resources exist only by virtue of being used in a practice" (Poole, Seibold, & McPhee, 1996, p. 117). This duality of structure is a continuous and indistinguishable cycle vacillating between human action and social structure.

Structuration is the production and reproduction of social systems through simultaneous interaction of structures and human agency to (re)create structures. In community-based mental healthcare, volunteer groups often use their agency and shared resources to help one another. For example, if one member needs free counseling, but cannot find a service to meet their needs,

others may offer their support, knowledge, or influence to help. If a member in a mental health crisis (e.g., a depressive episode) needs to connect with others who have similar experiences, the structured support group could enable that member to find support. Through these interactions volunteers structure and restructure not only what it means to live with mental illness, but also change the mental healthcare environment in which they reside.

Domination, Signification, and Legitimation

Giddens (1984) argued that social actors call on their understanding of social structure when determining action. While all structures in a given context are intertwined, Giddens separates these perceived structures into three types: domination, signification, and legitimation. Separating structures allows scholars to problematize and better understand how individuals negotiate complex structural systems. *Domination* refers to the power dynamics involving the allocation of both material and social resources in the organization. *Signification* refers to the interpretative schemes, including language and other symbolic interaction, of the social environment. *Legitimation* encompasses the norms and rules that are managed by members to sanction and encourage particular structures. Bloor and Dawson (1994) provide a simplified version of these three structures in organizations: (a) signification is the process of learning, modifying, and supplementing interpretive schema; (b) domination deals with the 'pecking order' determining who is in charge of what; and, (c) legitimation involves normative regulation or "the interplay between value standards and sectional interests" in terms of both agreement and disagreement (p. 278). Following a structuration theory framework, the following question was posed:

> **RQ1:** In what ways do legitimate, dominant, and symbolic structures enable and constrain volunteer member attempts to attain organizational goals?

Integrated Structuration: Action in Structure and Structure in Action

Aakhus et al. (2011) remind scholars that while social structures are foundations for human behavior and interaction, they are not deterministic, nor absolute. As an example, the deinstitutionalization movement restructured mental healthcare in the U.S. (Lamb & Bachrach, 2001). This change in mental healthcare structures was only possible through the agency of social actors. However, McPhee (2004) argues that agency emerges through the manifestation of the linguistic bases of human experience, labeled *texts*. In short, agency comes into being through everyday talk. Consequently, human agency yields texts that are (a) symbolic, (b) enduring, and (c) form coherent structures. Therefore, actors are enactive of the environments in which they reside. For example, the formation of a mental illness advocacy group, structures new realities, new network interactions, and discourses that would be otherwise inaccessible. As Archer (2007) explains, “no system can possess the reflexivity, intentionality, and commitment of the agents whose actions first produced and then continuously sustained these forms” (p. 38). Restated, while all actors have agency, all actions are still constrained and enabled by existing reflexively created structures. In this case, the vacuum of mental healthcare coordination left in the wake of deinstitutionalization presents structural barriers to community members. Heretofore, scholarly research has not investigated how volunteer mental healthcare groups discursive negotiate the current mental healthcare structures in the U.S. Thus, the following research question was posed:

RQ2: How do volunteer members (re)create structures to serve individuals with mental illness?

Method

As part of a larger program of mixed-method research on health volunteer efficacy, the

authors gained access to a volunteer organization whose mission was to support community members living with mental illness. A case-based method of inquiry was used to answer the proposed research questions. This case context was purposely chosen, given the suitability to the posed research questions and feasibility of the study to address these questions (Tracy, 2013). In case-based investigations, researchers proceed by choosing exemplar cases on the basis of theoretical interest in order to explore new concepts. Exemplary cases are not necessarily cases that are uncommon (e.g., outliers), rather they are cases in which the phenomenon in question can easily be observed and studied and hold strong potential for extending or challenging theory. Case-based research provides insight into how taken-for-granted structures and power-laden constraints function and are discursively negotiated through health volunteer's everyday talk (Dollar & Merrigan, 2002). Given the socially constructed nature of mental illness, an interpretive case-based method of inquiry is appropriate (Brown, 1995; Crossley, 2004). Case-based inquiry allows documentation of interactions among and influence of micro, meso, and macro levels of structure within the given context. With permission from the presidents of the organization and approval from our university institutional review board, the authors collected interviews ($N = 20$), organizational documents, and community health data. The following section provides a summary of the research context, data collection, and analysis.

Research Context

Centerville Mental Illness Advocacy (CMIA, all names are pseudonyms), is an all-volunteer nonprofit organization that serves individuals with mental illness and their families. CMIA is located in the city of Centerville in a Midwestern U.S. state and serves close to 100,000 citizens. The national CMIA organization was founded in 1979 and the CMIA chapter was founded four years later in 1983, notably during the deinstitutionalization movement. All CMIA

participation is voluntary. CMIA offers several formal services to individuals living with mental illness including: group therapy, family therapy, education classes for families, schools, and other audiences, as well as police training. CMIA connects those diagnosed with a mental illness to other community-based services. CMIA members work closely with other community-based nonprofits and governmental programs to aid individuals with mental illness including homeless shelters, Centerville Human Development Services, Centerville Behavioral Court, and the Centerville Community Center, which provides group therapy sessions, free lunch, and peer support groups.

Participants

CMIA member participation varies from those who receive a monthly newsletter, to members who have daily interaction with multiple board members and community services. Currently, CMIA recognizes close to 300 Centerville residents as “CMIA members,” (i.e., individuals who are loosely affiliated with they receive a monthly newsletter). A much smaller proportion of volunteers participate in services and events regularly (less than 40 participate weekly) as is common in many volunteer groups. Participants were selected purposely based on their level of involvement with the organization (i.e., board members or active non-board members). Given that these members participate often in furthering the CMIA mission, their perspectives relate specifically to the research questions posed. All current board members were included in the study ($n = 11$) as well as active non-board members ($n = 9$). Participant ages ranged from 29 to 75 ($M = 53.41$, $SD = 13.18$) Occupations varied among participants, including police officers ($n = 2$), retired teachers ($n = 3$), social workers ($n = 1$), a lawyer ($n = 1$), non-profit workers ($n = 2$), a full-time student ($n = 1$), and individuals on federal disability ($n = 3$). Participants’ tenure of CMIA membership ranged from 2 to 20 years ($M = 9.58$ years, $SD = 5.76$

years). Some participants disclosed that they became involved with CMIA after their own mental illness diagnosis (*n* = 10), while others joined after their family member went through a mental health "crisis" (*n* = 7). "Crisis" is a commonly used term by CMIA members and signifies that a person is a danger to themselves or others, is unable to function in normal activities, and/or needs an immediate healthcare intervention. Three participants interviewed did not have a mental illness, nor a family member with a mental illness. The board meets monthly and hosts several social events including weekly support groups, monthly classes, bi-annual workshops, and yearly attendance at state and national conferences. The CMIA board also maintains a website and newsletter, which is mailed to the entire membership.

Data Collection

In-depth Interviews. All members who were interviewed consented to be recorded. The authors solicited volunteers for interviews by sending emails to the board members and video conferencing during a board meeting. First, specific members were solicited to be interviewed based on their level of involvement with CMIA (i.e., co-president, secretary, website administrator). Next, interviews were expanded to include all board members (i.e., voting decision-makers within the organization) and through referrals from initial interviewees, active members were solicited. The authors continued to solicit participants until no new themes were seen within the interview dataset and data saturation was reached (see Guest, Bunce, & Johnson, 2006). During interviews, the study's purpose was explained via written and oral consent scripts. Eight of the interviews were conducted over the phone and 12 of the interviews were conducted face-to-face in the co-president's residence or at a local coffee shop. Steps were taken to ensure participant confidentiality and privacy (i.e., using a private space outside or a private dining room). All participants agree to be recorded, indicating their level of comfort with the interview

context. A semi-structured interview protocol was developed based on the theoretical questions of interest and early informal conversations with one of the co-presidents of CMIA. Questions related to member's motivations for continued involvement within the organization, perceptions of self-efficacy specifically related to legitimate, dominate, and symbolic structures influencing their experiences with mental illness (e.g., *What barriers do you face in providing support for individuals with mental illness? What resources might better serve individuals with mental illness?*). Interviews ranged in length from 21 to 73 minutes (M = 38.35, SD = 15.34).

Organizational Documents. The authors included the state resource CMIA handbook (84 pages), national and state MIA websites, and the CMIA chapter website and newsletters within the corpus of data. These documents served as supplementary data for providing a thick description of the context. This data also provided an additional contextual vantage point to view structural barriers or discrepancies in rules and structures at the local, state, and national levels of the organization. These data aided the authors understanding of the barriers and resources for individuals with mental illnesses and families in Centerville.

State and Municipal Mental Health Care Data and Laws. Primary interviews and informal conversations with the co-president about structural complexities in mental illness care prompted the authors to consider using structuration theory (Giddens, 1984) as a theoretical lens. This lens directed the authors to also consider macro structures (e.g., resources, laws, and socio-historical Discourses) governing interactions and mental health outcomes within the local CMIA context. Thus, state mental health care reports, current national and state laws pertaining to mental illness as well as relevant and significant U.S. Supreme Court findings, procedures for the Centerville behavioral health court, and a review of mental health deinstitutionalization research were consulted during analysis. This supplementary data aided the authors in answering RQ1.

Exemplars of how these structures constrained and enabled volunteers are included in the findings section and include citations of specific documents consulted with some information redacted to preserve participant confidentiality.

Data Analysis: Developing a Duality Analytic Method

An iterative and dynamic method of analysis was used to analyze the interview and organizational documents (see Tracy, 2013). This iterative process was accomplished in several steps. First, the interview data was read independently by both authors. During this step, initial thoughts and ideas were recorded through *in-process memos* (Emerson, Fretz & Shaw, 1995) and discussed in research meetings. Memos included author reflections on the processes, co-occurrences, and interesting information that was repeated across participant interviews. Next, the authors employed a process of abductive inquiry by reviewing data, reviewing theory, and then revisiting data (Peirce, 1839; 1914). The authors reviewed relevant literature (i.e., Giddens, 1979, 1985) to inform the next steps of data collection and analysis. The authors returned to data collection and analysis with Giddens's concepts of dominate, symbolic, and legitimate structures to seek out what were the current barriers and opportunities for agency within research context. Third, the authors re-read the data, this time reducing the interview dataset to descriptions of barriers and resources they utilized toward achieving their organizational mission(s) (Lindlof & Taylor, 2011). The authors used a lens of structuration theory to guide a process of data reduction. Specifically, the authors sought out descriptions and evidence of dualities within the dataset guided by the concepts of legitimation, domination and signification. Fourth, the authors began an iterative process of coding the reduced dataset (see Kramer & Crespy, 2011). This process began by coding the first piece of reduced data and placing it in a coding category. Then the authors read subsequent pieces of data and compared each with the prior codes. If the data fit

with the prior codes the data was placed in the same coding category. If the data did not fit, a new coding category was created. This process continued until all data was accounted for by the coding scheme and no new codes emerged. Fifth, the authors engaged in a process of axial coding in which they engaged in a second round of coding by investigating the relationships among the initial coding categories (see Lindlof & Taylor, 2011). The findings section provides exemplar excerpts from the dataset; however, the macro-level findings were thematic across participant interviews and archival data.

Qualitative Rigor

The authors took several steps to ensure high-quality qualitative research (Tracy, 2010). First, the authors engaged in a process of "crystallization" (see Ellingson, 2009) in which the authors collected multiple sources of data (i.e., multiple interviews, organizational documents), from multiple vantage points in terms of member power-status and roles within the organization in order to provide a clearer picture of the case. Second, the authors used a process of peer review. By presenting the initial coding scheme to a third researcher, who reviewed the plausibility of the coding scheme. Third, the manuscript includes a thick description of context and setting of the case. Finally, to relay faithfully participants' lived experiences, the authors engaged in member checking (see Stake, 1995; Creswell & Miller, 2000) with participants by asking two of them (i.e., one board and non-board member) to review the initial findings and coding categories. The authors also submitted a study summary and presented initial findings at their monthly board meeting. All suggested changes were implemented in the current version of the article.

Findings

The purpose of this study was to examine how specific structures enable and constrain

volunteer members in their organizational goal of supporting individuals with MI. Through a lens of structuration theory, data indicated specific dualities within the structures Giddens (1984) describes as: (a) domination, (b) signification, and (c) legitimation (see Table 1). At times volunteer members described how they (re)created these structures to act as change agents in their mission. However, these same structures also constrained members and served as barriers in a complex socio-political environment of mental illness care and maintenance. The relationships between these structures demonstrate the complexities of improving mental illness care, treatment, and support. The following section demonstrates how dominant, symbolic, and legitimate structures enabled and constrained this local volunteer group in providing support for community members living with mental illness. A final section highlights the interrelationships between these structures and how (re)creating structures might provide barriers as well as resources for those with mental illness treatment, care, and advocacy in community-based organizing.

[Insert Table 1]

Mental Illness Domination Structures within the Centerville Community

Mental illness domination manifests through the allocation of, and the authority associated with, material and social resources in the context of mental healthcare, support, and recovery. Examples of material resources include (a) monetary support, (b) amount of available in-patient beds, (c) number of available practitioners, (d) housing, (e) employment skills and opportunities, (f) medication, and (g) therapy. Examples of social resources include support groups, volunteer events, and education programs. Allocation of both material resources and social resources are based on power distribution. At times volunteers voiced perceptions of powerlessness and frustration at their inability to gain or control resources. Other times, they

demonstrated their agency to maximize, gain, and create resources to better serve those with mental illness.

Minimal Resources for Mental Illness. All volunteers within the group described significant deficits in community and healthcare resources for individuals with mental illness. Since deinstitutionalization in the mid 1950's, Centerville mental illness healthcare facilities have declined in availability and services provided. The number of psychiatric hospital beds available to patients with mental illness in Centerville has been reduced by 19.8 percent in the last 6 years (Ollove, 2016). Advocates for mental healthcare suggest that at least 40 beds be provided for every 100,000 residents, given the rates of mental illness in the general population. However, Centerville residents have a significantly lower ratio with 7.9 in-patient beds available per 100,000 residents (Ollove, 2016). Inpatient bed shortages are compounded by a lack of outpatient care due to a shortage of full-time psychiatrists in Centerville. According to a 2012 state report from the [Midwestern State] Department of Health Services, Centerville county needs 10.5 more full time psychiatrists to meet the federal minimum standard for mental health care provider-patient ratio: 1 per 20,000 residents ([State Name] DHS, 2012). These healthcare resource shortages constrain the support and perceived efficacy of CMIA volunteer members. All participants cited a lack of funding as a barrier to helping individuals with mental illness.

Mike, a CMIA member, explained "you can see historically where they closed a lot of the mental hospitals because the advocacy groups said that they were warehousing people. Rather than spend the money to give proper oversight, they closed them down." Here, Mike explains that from his perspective, discourse and public pressure from mental illness and civil rights advocacy groups, enabled law-makers to do less under the guise of supporting individuals living with a mental illness. The logic here is "if they are warehousing people, we should eliminate the

warehouse" without regard to the consequences to those in need of services. Advocate agency has the potential to restructure resources for those with mental illness in beneficial ways, but may result in unintended negative consequences.

Structural Barriers to Resource Access. As large state mental health institutions were closed in favor of community-based care, allocation of federal and state funds shifted to partnerships with local county services and nonprofit organizations in Centerville (and other communities) to fill the gap in mental health services (SAMHSA, 2014). This transition left Centerville mental healthcare fragmented—spread across local county services and federally funded non-profit agencies. This decentralization created a complex resource system that is challenging for individuals with high health literacy to navigate and even more challenging for mentally ill individuals living without support. This system complexity barrier is evidenced by CMIA Resource Guide publications, which states that navigating the current mental healthcare system in the county is "complicated and confusing," ([CMIA State Name], 2016). CMIA members also discussed their frustration about access to mental healthcare. CMIA co-president Piper explained that a major barrier to mental healthcare relates to system complexity. She states,

> "When I started this process 10 years ago, I thought, with my son's diagnosis, that we'd get out of the hospital and three days later there would be a coordinator calling me to set up services. *Are you kidding me?* There is no such thing. I had to be the case manager and coordinate these services. That still is true today for individual people" [Emphasis added to reflect speaker tone]

Piper's statement demonstrates her frustration with a complex, fragmented community-based healthcare system that places the burden of care coordination on families and volunteers.

Resource Agency: Volunteer Networking and Resource Creation. CMIA members

explained how they used agency to recreate some of the mental healthcare structures in their community and reduce fragmentation. Members discussed how they used networking as a way to integrate mental health resources from separate community organizations (e.g., law enforcement, the local housing authority, homeless shelters). Brittany, explained the benefits of their volunteer network. “I like that part of [CMIA] and the variety of people who sit around the table... I have resources that other people don't around the table, they have resources that I don't have.” Here, Brittany explains how the diversity of member leadership has helped to strengthen the efficacy of CMIA in helping individuals with mental illness. CMIA provides a central hub for resource sharing and integration of a fragmented community-based mental health system. Moreover, these diverse connections also allowed for inductive problem solving driven by individuals living with mental illness rather than prescribed allocation of resources from those in power. Maddie, a CMIA member, described her group's ability to create resources through networking and collaborative problem solving. She stated: “Sometimes they [a person with a mental illness] might be so individualized that there might not be a resource out there, but it's something that we should create and we should definitely be there to help people. And if there's not a resource, make one up.” In this excerpt, Maddie highlights the necessity of adapting resources to better serve individualized needs. Also, Maddie highlights CMIA member agency by explaining her ability to *create* resources. Multiple CMIA members demonstrated their agency through their descriptions of advocacy and resource creation including grant writing, fundraising, and recruitment of new volunteers.

For example, Peter, CMIA co-president, described with pride that the CMIA chapter operates solely through the “passion” and “energy” of volunteer members. When asked about the importance of a strictly volunteer model in CMIA, he explained, “We've always had a capability

of getting the team and I think if you look at our board of directors now, my gosh, they're fantastic." All board members described close relationships with Peter, who recruited almost all of the current 11-person board to take leadership roles in the organization. This recruitment was strategic based on their interconnectedness to other community organizations who serve individuals with mental illness (e.g., law enforcement, community housing, and education) or individuals who are in recovery. Peter is providing a mutually beneficial relationship by giving members purpose through membership in exchange for connection and resource sharing.

Mental Illness Signification Structures

Mental illness signification comes from the implicit or explicit symbolic forces that structure the life-worlds of individuals and families living with mental illness. The current symbolic landscape of mental illness in the Centerville community is partially a product of the perpetuation of negative mental illness discourse. Societal stigma associated with mental illness is well documented in health communication literature (Cabassa et al., 2014). In a review of two decades of research on the mass media's role in shaping the mental illness discourse, Klin and Lemish (2008) found that social perceptions of the mentally ill were negatively distorted as "peculiar," "different" and "dangerous." The authors' meta-review of the literature reinforces previous findings that discourses in the media perpetuate misconceptions and mental illness stigma. As evidence of the salience of mental illness stigma to CMIA members, all interview participants discussed stigma and mental illness. The word "stigma" was referenced 67 times throughout participant interviews without direct questioning about stigma from researchers. As further evidence of the presence of stigma, Brenda, a CMIA board member, described an encounter with an employee in the Department of Vocational Rehabilitation, while she was seeking employment and vocational training:

> ‘I can't get past feeling shameful about it or having then to speak about my mental illness, which is really not fair.’ And she says, ‘Well what do you do now?’ I said, ‘I'm a driving instructor and I train people behind the wheel.’ She says, and this is somebody that's a disability placement person, ‘*They let you do that*?’[Italics added to denote tone]

Here, the employee’s response of “they let you do that?” signifies an implicit mistrust and stigma discourse associated with a mental illness diagnosis. Brenda’s story demonstrates a deeply ingrained ideology about mental illness, which structures her ability to not only obtain employment, but also receive dignified treatment from the very agencies that are supposed to be supporting individuals with mental illness.

Resistant Symbolic Discourse. To further their mission, CMIA members used symbolic texts to resist negative mental illness discourses including: (a) breaking illness disclosure norms and (b) (re)framing mental illness. For example, Beth, CMIA board member and website curator, told a story about how she reacted to coworkers telling her to conceal her mental illness after she returned from in-patient mental health therapy. She explained:

> When I initially wanted to share what happened to me, there were certain people at my job that were like, ‘don't tell anyone this.’ That got me mad. So then I did a huge presentation on what happened. It was like, ‘here we go, don't tell me I can't do this.’ I wanted to break down the stigma, I'm not going to be alienated for this.

In this excerpt Beth uses her agency to overcome silencing norms about her mental illness. This symbolic act is re-structuring her own and others experience of mental illness as well as restructuring mental illness discourse and ideology in her workplace. In her story, she clearly describes her resistance to mental illness stigma through co-worker sanctioning discourses (e.g., “don’t tell me I can’t do this”). She also acknowledged her role in changing the scripts of mental

illness in this workplace context ("I wanted to break down the stigma").

CMIA members also described how changing their language use altered how they and others experienced and understood mental illness. Many participants demonstrated the (re)framing of mental illness as a way to accomplish their organizational goals. For instance, Brenda, described how her membership in CMIA changed how she talked about her mental illness as well as how she understood her mental illness. She explained her first experiences in CMIA groups: "They'd say, 'My name is Jim and I suffer from,' whatever mental illness it was. Then everybody started 'suffering' in the entire room...I thought this was just not good at all." She goes on to describe that she changed how she talked about mental illness, which in turn, changed how she and others experienced mental illness. Brenda explained further:

> I said, 'My name is [Brenda] and I'm challenged by bipolar. It's not always bad, but whatever.' Then, I was talking to some friends they said, '[Brenda], it's just like any other disease. You live with bipolar.' That's how I now present it and that's the way it is.

Brenda describes her own metamorphosis of understanding through a language shift in her reflection and description of mental illness. Her changing the script of "suffer" to "challenged by" to "live with" is no small point, as it highlights her own shift in identity from victim, to fighter, to a person living with a common health disorder. This framing of illness allowed Brenda to have an improved mental health experience as well as change the macro-level discourse of the mental illness of what it means to be mentally ill.

Mental Illness Legitimation Structures

The final category of structuring forces is legitimation: structures which create societal norms controlled by sanctions (see Carmack, 2010; Giddens, 1984). For the CMIA members,

legitimation pertains to normative structures and actions that shape and reshape the experience of mental illness and mental illness recovery. These normative structures often take the form of laws that carry both enabling and constraining qualities for CMIA members. The current legislation influencing the experiences of mental illness in the Centerville community is a product of specific socio-historic events including deinstitutionalization. CMIA members recognized that legitimation, or social norms, have both enabling and constraining qualities for individuals with mental illnesses as well as individuals who were trying to support others with mental illnesses.

Law as Constraint. CMIA members described how current legislation protects patient's rights, but at times reduces patient safety and care. As Matt, a member living with mental illness, explains, healthcare professionals "always have us sign something before we go through any kind of thing...We have people sign and make sure there's confidentiality and privatization..." However, confidentiality laws (e.g., HIPAA) also create conflict. Often family members are the main support for individuals with mental illness. Many times family members are able to describe symptoms that the patient cannot express, but the law restricts this type of third party information sharing. Bob, a CMIA board member, noted that while families can write a psychiatrist a letter, the psychiatrist "... won't even acknowledge they got it, 'cause they can't acknowledge anything about the patient unless the patient gives them permission." Confidentiality laws protect patient rights, but often at the cost of support and information sharing between families and physicians. Mike, a CMIA member echoes Bob's assertion by stating "it's been my experience dealing with hospital personnel is that they use the HIPAA law to give bad service, and not for what it was intended, to prevent abuses." Here, Mike highlights the irony and unintended consequences of confidentiality laws upon the individuals living with

mental illness in terms of the provision and access to healthcare and support. The law protects both patients and hospital workers, but the invocation of the law may be creating barriers of information exchange among caretakers, patients and healthcare providers.

Similarly, physician's diagnostic scripts structure mental healthcare because they determine, by law, whether or not patients will be admitted to a hospital. For example, if a patient affirms that they may harm themselves or others they must be admitted and placed on an involuntary 72-hour hold in a secure care facility. Given that these scripts are normative, many participants acknowledged that individuals with mental illnesses know how to respond to questions to maintain control of decision-making about their illness. Mike elaborates many "[Patients] know the system better than the people who are trying to help them. They know, [physicians] ask you 'Are you feeling suicidal?' You know...you may end up in jail, or into the hospital...so you say no." While these scripts allow individuals with mental illness to maintain control, they may also be a barrier to physicians obtaining accurate information about the patient's actual mental state. Mike, and many other CMIA members claim that when family members are involved, "they're the best source of care in most instances for these people." Many members privilege patient recovery and family healthcare decision making over patient decision-making. They also recognizes that the unintended consequence of deinstitutionalization and patient rights legislation often create barriers for care and treatment. As a result, the rights of a patient and the safety of that patient (and society) remain in flux as policymakers and CMIA members try to serve the best interests of all involved.

Furthermore, CMIA members who are also police officers provided in-depth descriptions of the unintended consequences of patient's rights law. Brittany explained that even when a police officer finds evidence of intent to harm oneself, that is no guarantee that a "chapter" (i.e.,

temporary institutionalization) will be granted. She recalled an interaction in which she was trying to convince a healthcare worker to chapter an individual. She stated, "…here's the notebook, her journal, she has written in her own blood, can you please let me chapter her? *No.*" As Brittany describes, the legal process of chaptering simultaneously enables and constrains the *in situ* decision processes of actors in the community model of mental healthcare. Her experience demonstrates legal constraint as a result of patient's rights legislation. However, these constraints are not absolute. Recently, Centerville County revised the legal process of obtaining a chapter. Previously, a 3-signature method (e.g., physician, police officer, and witness) was required for chaptering. As a result of CMIA advocacy, now all chapters are filtered through a single crisis agent in one county agency. This re-structuring of legal processes demonstrates the agency members have to enact new realities for community mental health organizing.

Invoking Law as Agency. While many participants described the constraining qualities of mental illness legitimation structures, they also described a number of ways in which CMIA members try to circumvent the sanctioning system within the context of mental health rehabilitation in Centerville. First, CMIA offers a specialized program to train law enforcement officers to recognize individuals who are experiencing a mental illness crisis as well as provide them with communicative tools to de-escalate the situation. The police officers on the CMIA board, discussed how the program focused on connecting people with mental healthcare resources in lieu of incarceration. Brett explained, officers serve as a "go between… 'cause if someone's having mental illness, they don't have the ability necessarily to make decisions or make sound decisions." CMIA training allows officers, who are often first responders to mental health crises, to recognize behavioral cues associated with mental illness and to act as a bridge to connect the individual to the correct community resource, while adhering to legal obligations of

the job.

Another way CMIA members invoked law-as-agency was with the creation of a separate mental health courts system. Established in 2013, the Centerville County Behavioral Court, helps provide stability to those with mental illness and reduce recidivism to the criminal court system (CMIA, 2017). Individuals are referred to the behavioral court by a county judge if they have a history of criminal convictions and a severe, persistent mental illness. Peter, CMIA co-president, served as an advisor on the behavioral court board and he explained how he wanted to provide an alternative to (re)institutionalizing patients with mental illness by supporting them through structured care and rehabilitation. He stated, “the whole purpose of a treatment court, specialty court, is to provide treatment instead of incarceration.” Furthermore, Peter explained that not only did the CMIA board influence the creation of the alternative court in Centerville, but they also collaborated with various county agencies to provide support to individuals in crisis. Peter explained, “They can go help out, volunteer. You screw up and so with that, you get sanctioned sometimes, so maybe they go to help out for a week at [the community center], but in doing so, they can also attend the support sessions. It's fantastic.” Here, Peter describes the behavioral court as a new system of sanctioning where this court’s sentences (e.g., compulsory community service) are designed to encourage participation in country rehabilitation services. In sum, legitimation structures are complex. The tensions between patient’s rights laws and patient protection structure and re-structure CMIA member actions and efficacy towards their goals. The following section discusses the findings in relation to theory and applied practice.

Discussion

The purpose of this study was to understand how mental illness is structured through the actions of a volunteer organization. Specifically, this research explored the structures enabling

and constraining a group dedicated to support and advocate for the community of people with mental illness. Using structuration theory as a frame for understanding the complex structures in the mental health care context, a duality analysis revealed co-occurring elements of constraint and opportunities for agency. Constraints for participants within dominant, symbolic, and legitimate mental illness structures included: (a) minimal mental health resources, (b) poor access to mental health resources, (c) negative mental illness discourse, and (d) legal tension between patient's rights and safety.

Within each substructure, participants also demonstrated their agency to overcome systemic barriers to their organizational goals—often through communicative means with minimal resources. In structures of domination, members utilized networking, advocacy, and resource creation. In signification structures, members engaged in resistant discourse, promoted community education programs, and used their voice to change mental illness stigma discourse. In legitimation structures, members utilized, called upon, and altered formal policies, court systems, and laws to further their goal of supporting community members with mental illness. These findings demonstrate the integral role community-based healthcare organizations can provide to members, clients, and communities through their volunteer member agency. This article provides three major theoretical contributions to health theory, organizational theory, and the study of volunteer organizations.

Nuanced Interplay of Micro and Macro Discourse

First, this case study documents the interaction of micro and macro discourses. Modern critiques of healthcare and organizational studies contend that too many studies focus either on micro or macro levels of discourse and do not investigate and problematize how the two are not only interrelated, but how the might be enactive of one another (Conrad & Haynes, 2001).

Giddens' (1984) concept of the duality of structure, explains that structures are both the process and product of micro discourse and macro level structures that manifest through everyday talk (Giddens & Pierson, 1998). Using an integrated perspective of action and structure, structuration theory allows researchers to analyze the situatedness of action (Conrad & Haynes, 2001; Poole, Seibold, & McPhee, 1985). In this case, CMIA members identified several structures that created barriers to quality mental health rehabilitation in their community. Members also demonstrated their ability to appropriate, change, and recreate structures to better serve their community (e.g., mental health courts, creating new mental health scripts). This study’s contribution to theory is the documentation of the situatedness of volunteer action in the complex context of community-based mental healthcare. Through this analysis, the authors were able to not only document the complexities of mental illness care, but also reveal hidden resources, agency, and unintended consequences of (re)structuring action within the volunteer community healthcare context.

Agency and Unintended Consequences. The use of agency prompts both intended and unintended consequences, via additional structures (Giddens, 1984). For instance, while CMIA successfully advocated to change the chaptering process, the new process also limited the decision-making ability of local police officers. CMIA board members, especially the police officers, discussed frustration with the new process and not being able to chapter an individual who, from their perspective, clearly needed help. As Giddens (1984) explains, each agentic action creates additional, often unintended structures that enable and constrain future action. For example, the new behavioral court system in Centerville is intended to provide an alternative to the traditional criminal justice system and is touted by CMIA co-president Peter as “fantastic.” However, the new system also created, ironically, new and different structures of domination and legitimation for individuals with mental illness.

While research has documented the benefit of integrating mental health rehabilitation programs with criminal justice systems (Ferrazzi & Krupa, 2015; Segal, Frasso & Stisti, 2018), CMIA members critiqued this new system—a system implemented as a result of CMIA advocacy. CMIA member Mike explained that although his son benefitted from the behavioral court, the requirements (e.g. drug testing, group therapy, court hearings) are very challenging to meet without reliable transportation and while his son tries to maintain employment. Similarly, Brooke, a CMIA board member, described how she and her husband cannot easily travel out-of-state because they are the main source of support for their son and he is under a conditional release from the court. In sum, while the agency of CMIA members created structures that aided individuals living with mental illness and families, at times these new structures also created new challenges to those living with mental illness.

Bureaucratic Complexity and Obscuring of Structure.

While CMIA members were able to use agency to circumvent structural barriers to their mission, it was also apparent that system complexity and complex legal language obscured structures influencing mental healthcare in their community. Organizational scholars and theorists contend that as structures become less visible they also become particularly hard to resist and change (Barker, 1993; Tompkins & Cheney, 1985). In other words, actor agency is affected by the extent to which a structure is made visible. For example, when participants were asked about current healthcare laws, some CMIA members disclosed that they had little knowledge of laws that affected them and their mission. For example, CMIA member Megan stated, “So as for laws I really don't know much about that.” Similarly, Macy explained, “that's an area that I'm not as well versed in as I should be probably.”

Foucault (1990) argued that controlling structures are especially powerful if they are

obscured or go unrecognized. He explained that "Power is tolerable only on the condition that it masks a substantial part of itself. Its success is proportional to its ability to hide its own mechanism" (p. 168). Similarly, in this case, the reification of certain problematic, complex and therefore obscured structures (e.g., HIPPA, chaptering processes, mental illness insurance coverage) were successful in part due to a lack of public knowledge of and engagement with such structures. For example, CMIA member Matt explained his lack of knowledge of mental health laws in relation to never encountering laws that affect individuals living with mental illness, stating "Laws ... I've never really had any kind of legal experience." As a result the problems created by these structures were only made visible when individuals living with mental illness or their family members encountered unintended consequences of these obscured structures. As such, the invisibility of some structures created a barrier to CMIA's support of the mental health community. Further, research could be done to understand how obscured structures might be made more visible on a meso a macro level in providing support for individuals living with mental illness.

Duality Analysis: Building Methods for Understanding Complex Health Contexts

A second methodological contribution this study provides is an example of a duality analysis. This analysis focused on the structurational context of member experiences as well as how their discourse reinforced or recreated the context in which they functioned. Previously, scholars have critiqued the use of structuration theory in empirical work given the abstract general propositions and that it is not easily coupled with a specific methodological approach (Archer, 2007; Pozzebon & Pinsonneault, 2005). While communication scholars have employed structurational perspectives to various healthcare phenomenon (e.g., informed consent laws, space and materiality, physician apology laws), this study extends structuration methods with a

volunteer group (Carmack, 2010a, 2010b; Olufowote, 2008, 2009). A duality analysis was conducted by including multiple sources of discourse (e.g., law and policy texts, member accounts, behavior, and resource data) and analyzing these data iteratively by focusing on sub-categories of structure: domination, signification, and legitimation. This type of guided analysis yielded findings that highlight the barriers, paradoxes, and double-binds, present with the current community-based mental healthcare system. In this case, the analysis demonstrated the tensions among discourses of patient rights, patient healthcare access, and patient protection. Additionally, this case showed the double-bind of member agency, which both helped and harmed individuals and families living with mental illness.

Furthermore, our findings demonstrate how current mental health structures created difficulties for CMIA member goal attainment. The duality analysis also demonstrated hidden resources and obscured avenues for agency CMIA members utilized toward their organizational mission of serving community members with mental illness. For example, CMIA co-president Peter's role in advocating for a separate judicial system demonstrates his agency over the trend towards incarceration rather than rehabilitation of individuals with mental illness (cf. Henry et al., 2015). Given this wide range and application of structuration theory, a duality analysis provides a system for conceptualizing and troubleshooting barriers to volunteer work. This type of analysis might be applied fruitfully to other complex healthcare contexts to not only better understand patients' lived experiences but also uncover overlooked resources and obscured solutions to structural issues.

Resource Creation as Agency in Volunteer Organizations

Giddens (1984) concept of agency explains how actors are enactive of the environments in which they reside, while simultaneously being constrained by the current structural context and

their current and previous actions. The most substantial contribution of current study is the documentation of resource creation by a volunteer healthcare organization. Although social norms, healthcare policy, legal statutes, and a lack of resources often created barriers to the group's efficacy, members remained steadfast in their willingness to act for their cause. Within each structure type, CMIA members demonstrated their ability to create change and cultivate resources with a fully volunteer workforce. Similar to Hayek's (1945) work that articulated why frontline workers see problems and solutions that managers often do not, CMIA members also have tacit, frontline experience to provide practical solutions to important mental healthcare problems. Given that CMIA volunteers are close to mental illness crises, they also often had the most creative and viable solutions to mental healthcare reform—most notable was the creation of resources through community networks and savvy language shifts. These communicative resources are low cost to volunteers and the organization, but have the potential to overcome the complexities and barriers to care in the current mental healthcare model (e.g., low access to mental health resources, stigma, mistrust and non-disclosure of mental illness).

Another essential resource was created by changing the mental model (see Weick, 1995) of a mentally ill person's role within their own advocacy and their contribution to solving mental healthcare problems. Researchers have documented social mistrust and stigma associated with individuals living with mental illnesses (Klin & Lemish, 2008). As a result, their skills and talents have been overlooked as a viable resource to solve current problems in mental healthcare. CMIA members, both with and without mental illnesses, described individuals with mental illness as hidden resources for their cause and the community. This resource development is no small point because, as members explained, individuals with mental illness supporting others with mental illnesses functions as a two-layer resource/benefit. On one level they are serving CMIA's mission

through mentoring, fundraising, and educating. On another level, this service is a mechanism for their own healing and rehabilitation. An example of this is in the storytelling education program, where individuals with mental illness tell personal narratives of their mental illness experiences to public school children in hopes of making mental illness discussable in everyday talk. Similar to other work on narrative intervention (e.g. Petraglia, 2007), storytelling by individuals with mental illness as well as positive feedback from the audience functions as catharsis for presenters. Audience members with mental illness who have felt stigmatized in the past now often have the courage to disclose their own mental illness and seek help. In sum, these findings reveal untapped and underutilized resources that may have been overlooked because of biases, stigma, and taken-for-granted assumptions. Other volunteer organizations and nonprofit groups might also employ a duality analysis to their contexts to better map resources obscured by dominant discourses and structures.

Limitations

Given the unique context of the case, our findings should be applied to other contexts with care. However, several of the lessons this study provides may be transferred to other similar contexts. Researchers and practitioners alike may benefit from engaging in duality analyses. Given our purposive sample of highly involved group members, future work should also consider perspectives of loosely affiliated members in volunteer health advocacy groups and how their roles might be expanded and utilized towards the group's mission. In sum, structuration theory offers insight to situations in which barriers stand in the way of action. Reducing complex healthcare landscapes by focusing on specific structures that create barriers to rehabilitation and recovery, might also highlight the ways in which systematic, evidence-based interventions might be developed and managed at the community level.

References

Alvesson, M., & Kärreman, D. (2000). Varieties of discourse: On the study of organizations through discourse analysis. *Human Relations*, *53*, 1125-1149. https://doi.org/10.1177/0018726700539002

Aakhus, M., Ballard, D., Flanagin, A. J., Kuhn, T., Leonardi, P., Mease, J., & Miller, K. (2011). Communication and materiality: A conversation from the CM Café. *Communication Monographs*, *78*, 557-568. https://doi.org/10.1080/03637751.2011.618358

Archer, M. S. (2007). The trajectory of the morphogenetic approach: an account in the first-person. *Sociologia, Problemas, e Práticas, 54*, 35-47.

Bloor, G., & Dawson, P. (1994). Understanding professional culture in organizational context. *Organization Studies*, *15*(2), 275-295. https://doi.org/10.1177/017084069401500205

Brown, P. (1995). Naming and framing: The social construction of diagnosis and illness. *Journal of Health and Social Behavior*, *Extra Issue,* 34-52. https://doi.org/10.2307/2626956

Cabassa, L. J., Siantz, E., Nicasio, A., Guarnaccia, P., & Lewis-Fernández, R. (2014). Contextual factors in the health of people with serious mental illness. *Qualitative Health Research*, *24*, 1126-1137.

Carmack, H. J. (2010a). "What happens on the van, stays on the van": The (re) structuring of privacy and disclosure scripts on an appalachian mobile health clinic. *Qualitative Health Research*, *20*(10), 1393-1405. https://doi.org/10.1177/1049732310372618

Carmack, H. J. (2010b). Structuring and disciplining apology: A structurational analysis of health care benevolence laws. *Qualitative Research Reports in Communication*, *11*, 6-13. https://doi.org/10.1080/17459430903413432

Conrad, C., & Haynes, J. (2001). Development of key constructs: Views from varying perspectives. In F. Jablin & L. L. Putnam (Eds.), *The new handbook of organizational communication* (pp. 47-77). Newbury Park, CA: Sage.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into practice, 39*(3), 124-130. https://doi.org/10.1207/s15430421tip3903_2

Crossley, N. (2004). Not being mentally ill. *Anthropology & Medicine, 11*, 161-180. https://doi.org/10.1080/13648470410001678668

Dollar, N. J., & Merrigan, G. M. (2002). Ethnographic practices in group communication research. In L. R. Frey (Ed.), *New directions in group communication* (pp.59-78). Thousand Oaks, CA: Sage.

Ellingson, L. L. (2009). Ethnography in applied communication research. In L. R. Frey & K. N. Cissna (Eds.), *Routledge handbook of applied communication research* (pp. 129-152). New York, NY: Routledge.

Emerson, R.M., Fretz, R.I. & Shaw, L.L. (1995) *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press. https://doi.org/10.7208/chicago/9780226206851.001.0001

Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and reinstitutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, *6*, 313-316. https://doi.org/10.1016/j.mppsy.2007.05.008

Ferrazzi, P., & Krupa, T. (2015). Therapeutic jurisprudence in health research: Enlisting legal theory as a methodological guide in an interdisciplinary case study of mental health and criminal law. *Qualitative Health Research, 25*, 1300-1311.

Foucault, M. (1990). *The history of sexuality: The use of pleasure* (Vol. 2). New York, NY: Random House.

Giddens, A. (1979). *Central problems in social theory: Action, structure, and contradiction in social analysis*. Berkeley, CA: University of California Press.

Giddens, A. (1984). *The constitution of society: Outline of the theory of structuration*. Berkeley, CA: University of California Press.

Giddens, A., & Pierson, C. (1998*). Conversations with Anthony Giddens: Making sense of modernity*. Redwood City, CA: Stanford University Press.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18,* 59-82. https://doi.org/10.1177/1525822X05279903

Henry, M., Shivji, A., de Sousa, T. & Cohen, R. (2015) *The 2015 Annual Homeless Assessment Report (AHAR) to Congress*. The U.S. Department of Housing and Urban Development. Retrieved from: https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf

Hayek, F. A. (1945). The use of knowledge in society. *The American Economic Review, 35*, 519-530.

Jane-Llopis, E., Anderson, P., Stewart-Brown, S., Weare, K., Wahlbeck, K., McDaid, D., & ... Litchfield, P. (2011). Reducing the silent burden of impaired mental health. *Journal of Health Communication*, *16* 59-74. https://doi.org/10.1080/10810730.2011.601153

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of Health Communication, 13*, 434-449. https://doi.org/10.1080/10810730802198813

Kramer, M., & Crespy, D. (2011). Communicating collaborative leadership. *The Leadership Quarterly, 22*, 1024-1037. https://doi.org/10.1016/j.leaqua.2011.07.021

Krieg, R. G. (2001). An interdisciplinary look at the deinstitutionalization of the mentally ill. *The Social Science Journal*, *38*, 367-380. https://doi.org/10.1016/S0362-3319(01)00136-7

Lamb, H. R., & Bachrach, L. L. (2001). Some perspectives on deinstitutionalization. *Psychiatric Services*, *52*(8), 1039-1045. https://doi.org/10.1176/appi.ps.52.8.1039

Lefley, H. P. (1996). *Family caregiver applications series, Vol. 7: Family caregiving in mental illness.* Thousand Oaks, CA: Sage Publications.

Lewis, L. (2014). An introduction to volunteers. In Kramer, M. W., Lewis, L. & Gossett, L. M. (Eds.) *Volunteering and communication: Studies from multiple contexts*. (pp. 1-24). New York: NY. Peter Lang.

Lindlof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Thousand Oaks, CA: Sage.

Link, B., Mirotznik, J., & Cullen, F. (1991). The effectiveness of stigma coping orientations: Can negative consequences of mental illness labeling be avoided? *Journal of Health and Social Behavior, 32*, 302-320. https://doi.org/10.2307/2136810

McPhee, R. D. (2004). Text, agency, and organization in the light of structuration theory. *Organization, 11*, 355-371.

Nakash, O., Cohen, M., & Nagar, M. (2018). “Why come for treatment?” Clients’ and therapists’ accounts of the presenting problems when seeking mental health care. *Qualitative Health Research, 28*, 916-926.

Ollove, M. (2016). Amid shortage of psychiatric beds mentally ill face long waits for treatment. *Stateline.* Retrieved from: http://www.pewtrusts.org/en/researchandanalysis/blogs/stateline/2016/08/02/amidshortageofpsychiatricbedsmentallyillfacelongwaitsfortreatment

Olufowote, J. O. (2008). A structurational analysis of informed consent to treatment: Societal

evolution, contradiction, and reproductions in medical practice. *Health Communication*, *23*, 292-303. https://doi.org/10.1080/10410230802056404

Olufowote, J. (2009). A structurational analysis of informed consent to treatment: (Re) productions of contradictory sociohistorical structures in practitioners' interpretive schemes. *Qualitative Health Research*, *19*, 802-814. https://doi.org/10.1177/1049732309335605

Peirce, C. S. (1839, 1914). Collected papers of Charles Sanders Peirce. In A. W. Burks (Ed.) *Bibliography of Charles S. Peirce.* (Vol. 8) Retrieved from http://hdl.handle.net/2027/mdp.39015026458060

Perry, B. L. (2016). *50 Years after deinstitutionalization: Mental illness in contemporary communities*. Somerville, MA: Emerald. https://doi.org/10.1108/S1057-6290201617

Petraglia, J. (2007). Narrative intervention in behavior and public health. *Journal of Health Communication*, *12*, 493-505. https://doi.org/10.1177/1049732309335605

Poole, M. S., Seibold, D. R., & McPhee, R. D. (1985). Group decision-making as a structurational process. *Quarterly Journal of Speech*, *71*, 74-102. https://doi.org/10.1080/00335638509383719

Pozzebon, M., & Pinsonneault, A. (2005). Challenges in conducting empirical work using structuration theory: Learning from IT research. *Organization Studies*, *26*, 1353-1376.

Reichertz, J. (2010). Abduction: The logic of discovery of grounded theory. *Forum: Qualitative Social Research, 11*. Retrieved from http://www.qualitative-research.net /index.php/fqs/article/view/1412/2902

Richter, C. J. (2000). Anthony Giddens: A communication perspective. *Communication Theory*, 10, 359-368. https://doi.org/10.1111/j.1468-2885.2000.tb00197.x

Rothbard, A. B., & Kuno, E. (2000). The success of deinstitutionalization: Empirical findings from case studies on state hospital closures. *International Journal of Law and Psychiatry*, *23*, 329-344. https://doi.org/10.1016/S0160-2527(00)00042-X

Segal, A. G., Frasso, R., & Sisti, D. A. (2018). County jail or psychiatric hospital? Ethical challenges in correctional mental health care. *Qualitative Health Research, 28*, 963-976.

[State Name] Department of Health Services. (2012) Psychiatrist FTEs needed to remove significant shortages by county. Retrieved from: https://www.dhs.statename.gov/anonymizedlink.pdf

Substance Abuse Mental Health Services Administration. (2014). Community mental health services block grant. Retrieved from: https://www.samhsa.gov/grants/block-grants/mhbg

Stake, R. (1995). *The art of case study research.* Thousand Oaks, CA: Sage

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, *60*, 761-765. https://doi.org/10.1176/ps.2009.60.6.761

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*, 837-851. https://doi.org/10.1177/1077800410383121

Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. West Sussex, UK: John Wiley.

Tsang, H. W., Tam, P. K., Chan, F., & Chang, W. M. (2003). Sources of burdens on families of individuals with mental illness. *International Journal of Rehabilitation Research*, *26*, 123-130. https://doi.org/10.1097/00004356-200306000-00007

Weick, K. E. (1995). *Sensemaking in organizations.* Chicago, IL: Sage.