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Tomi Gomory and Daniel Dunleavy

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Tomi Gomory, Ph.D., MSW

Dan Dunleavy, MSW

College of Social Work, Florida State University

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Abstract

Social work is perhaps most distinctive for its clear and outspoken commitment toward improving the well-being of society's vulnerable and disadvantaged groups, while still emphasizing the importance of respecting and defending personal rights and freedoms. Though there is a fundamental necessity for coercion, or its threat, for eliciting civil social behavior in a well-functioning society, it is professionally and ethically imperative that social workers make explicit our rationales for, justifications of, and the evidence used to support or reject coercive practices in our work. Social work's engagement with coercion inevitably entails the ethical and social policy arguments for and against its use, as shown in a review of the empirical evidence regarding its impact on the professions' clients, exemplified by three domains: (1) child welfare, (2) mental health, and (3) addictions. Recommendations for future improvements involve balancing the potential for harm against the benefits of coercive actions.

Keywords

coercion, social work ethics, social work practice, mandated treatment, involuntary hospitalization, mental health, risk assessment, child welfare. drug abuse

Introduction

The International Federation of Social Workers (IFSW, 2016) in its statement of ethical principles boldly declares as its very first principle the importance of addressing the human rights and human dignity of all people:

> Social work is based on respect for the inherent worth and dignity of all people, and the rights that follow from this. Social workers should uphold and defend each person's physical, psychological, emotional, and spiritual integrity and well-being. This means:
>
> 1. Respecting the right to self-determination—Social workers should respect and promote people's right to make their own choices and decisions, irrespective of their values and life choices, provided this does not threaten the rights and legitimate interests of others.
> 2. Promoting the right to participation—Social workers should promote the full involvement and participation of people using their services in ways that enable them to be empowered in all aspects of decisions and actions affecting their lives. (p. 2)

And in its statement on Professional Conduct, the IFSW specifically rejects unwanted inhumane treatment, "Social workers should not allow their skills to be used for inhumane purposes such as torture" (p. 2). Despite this clear and explicit ethical commitment to self-determination and autonomy of clients in controlling their own lives, the fact is that compulsory approaches (involuntary, mandated, or forced treatments) are common and

fundamental elements (Reid, 1992, p. 40) of Social Work's professional practice armamentaria in all major areas of practice (including mental health, intellectual disability, child welfare, drug addiction, care of the elderly and the poor, and most visibly in the criminal justice system). In academia, professional texts focusing on coercive treatment are occasionally part of the helping profession's curriculum (e.g. Dennis & Monahan, 1996; Kallert, Mezzich, & Monahan, 2011). In daily practice, social workers frequently act as mandated reporters (legally expected identifiers of suspected harmful behavior often resulting in legal sanctions against those identified, in both child welfare and elder care) and are the frontline workers providing involuntary services in many of the fields previously identified.

Given that there are approximately 649,300 social workers in the United States alone (U.S. Department of Labor, 2016), coercive practices would appear to be a particularly salient professional issue and a common ethical dilemma in day-to-day practice. This may seem obvious in settings in which professional coercion is openly acknowledged and routinely deployed, such as the criminal justice system, which employs thousands of social workers (Wilson, 2010, p. 2). However, coercive behaviors can also be found among the seemingly more altruistic subfields. Social workers are by some accounts the dominant professional presence in the field of mental health, with approximately 255,000 clinical social workers comprising the largest individual profession delivering mental health services (Gomory, Wong, Cohen, & Lacasse, 2011; Whitaker & Arrington, 2008). It is estimated that currently in the United States between three and four million mental health clients are subject to at least one form of psychiatric coercion in any given year (Kirk, Gomory, & Cohen, 2013, p. 87), meaning that social workers are regularly engaged in direct or indirect practices that appear to conflict with the ethical mandates described by the IFSW. In the United Kingdom there are also concerns about the increasing use of coercion in mental health services. For example, in England 48,600 people were detained under the Mental Health Act in 2011–

2012, which was a 5 percent increase from 2010–2011; while the number of people discharged from the hospital under community treatment orders (CTOs) rose by 10 percent during the same period (Health and Social Care Information Centre, 2012). Additionally, although the number of children in government care, in the United Kingdom, has declined over the last 30 years, the numbers have since risen between 2008 and 2011 from 81,315 to 89,620 (National Society for the Prevention of Cruelty to Children [NSPCC], 2012); with the number of children in care for abuse and neglect rising to 42,470 as of 2016 (NSPCC, 2017, p. 66).

Though there is a fundamental necessity for coercion, or its threat, in order to maintain a civil society (Popple, 1992, p. 151), it is professionally and ethically imperative that social workers make explicit the rationales for, justifications for, and the evidence used to support or reject coercive practices in our "helping" work. In this article social work's general engagement with coercion is examined, with a discussion of the ethical and social policy arguments for and against its use, and a review of the empirical evidence regarding its impact on the profession's clients, exemplified in three important domains: 1) child welfare, 2) mental health, and 3) addictions. The discussion concludes with some comments for what might be done in the future, keeping in mind social work's stated commitment as articulated by the IFSW (2016) that the profession's work is to be based:

> [O]n respect for the inherent worth and dignity of all people, and the rights that follow from this. Social workers should uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being.

A few caveats, however, are in order. Although professional social work has grown exponentially over the past century, and has recently adopted a much more global perspective, the focus here will be primarily on facets of coercion common to the United States and to a degree in Europe based on the available literature. With that being said, the

discussion about the use of coercion, the assumptions underlying its use, and the empirical status of the variety of its practices are salient to social workers all over the world because of the universal application of coercion, if and when techniques of persuasion fail to obtain behavior control in the social world (Peckham, 1979). Additionally, although the fields of practice discussed below are of particular importance to the profession of social work, they are certainly not unique to that profession. Many of the practices and policies discussed below are embedded in a network of "helping professionals," including but not limited to psychologists, psychiatrists, marriage and family therapists, mental health counselors, and psychiatric nurses, which means that purportedly helpful coercive actions are not unique to the profession of social work and that our analysis may prove fruitful for these other fields as well. However, among these helping professions, social work is perhaps most distinctive in its clear and outspoken commitment toward improving the well-being of society's vulnerable and disadvantaged groups, while still emphasizing the importance of respecting and defending personal rights and freedoms. The importance of individual freedom and self-responsible behavior to reduce personal and interpersonal life difficulties should not be lost, especially within the context of increasing intraprofessional medicalization of personal and social problems as pathology (Conrad & Schneider, 1992) and the continued professional utilization of various mechanisms of social control (see for example Cohen & Scull, 1986). It is with this in mind that the topic of coercion and the contemporary background informing this issue should be examined.

Background

Although coercive practices are widespread, the academic research regarding its positive impact on clients is at best highly variable. Churchill et al. (2007, p. 7) concluded, on the

basis of a systematic review of the available international research literature on Community Treatment Orders (CTOs are legally mandated outpatient mental health treatments), that there is "currently no robust evidence about either the positive or negative effects of CTOs on key outcomes, including hospital readmission, length of hospital stay, improved medication compliance, or patients' quality of life." Similarly, in efforts to reduce misuse of psychoactive drugs, coercive or mandated treatments don't seem to do any better than voluntary approaches, although sometimes they may have some unanticipated adverse effects such as earlier recurrence of the substance use (Brecht, Anglin, & Dylan, 2005). Another recent review of the effectiveness of coerced treatment for drug users concluded that coerced treatment:

> "[C]an be as effective as treatment that is entered voluntarily, but is not generally more or less effective than such voluntary treatment. This general finding is supported by research on drug courts in the USA, on drug treatment and testing orders in the United Kingdom and by systems of quasi-compulsory treatment in other European countries. (Stevens, 2012, p. 14)

Rittner and Dozier (2000) further report that in their study which:

> "[E]xamined the effects of court orders in preventing recurrence of substance abuse in the cases of 447 children in kinship care while under CPS supervision. . . . Results suggested that court interventions had mixed outcomes. Levels of compliance with mandated substance abuse and mental health treatment did not appear to influence rates of reabuse or duration of service. . . . Children adjudicated dependent were more likely to have multiple caretakers than those under voluntary supervision." (p. 131)

Regardless of these fairly consistent empirical findings across practice domains, there has been more and more focus in academic research on the use of coercive treatment. A search evaluating the use of psychiatric coercion found that in

> "[T]he Medline database up to and including 2007 for indexed articles about psychiatric coercion (using *coercion, outpatient commitment,* and *civil commitment* as independent key words), we identified 796 articles. Only 22 articles were published before 1970, in contrast to 665 articles between 1991 and 2007 (39 articles a year). The first noticeable spike in publications occurred in 1971, around the time community treatment became a focus of research." (Kirk, Gomory, & Cohen, 2013, p. 109)

So paradoxically, the supposedly freedom-enhancing venue of treatment in the community appears to have engendered instead more coercive approaches on more people. Although the site of coercion has changed, the volume of the practices has been increasing rather than attenuating (Kirk et al., 2013).

The research literature on social work and coercion has also tended to focus on legally mandated coercion, such as compulsory admission to hospital, but the use of coercion by social workers is much more widespread and complex than these formal powers (Campbell & Davidson, 2009). Definitions of coercion include subtle and suggestive methods of gaining outcomes, from implicit threats toward noncompliant service users to the explicit use of physical force (Lutzen, 1998). For this reason, it is useful to think of the concept in terms of a continuum, from persuasion through pressure to force; although it may still be difficult to agree about the point at which nondirective discussion ends (strongly expressed family concern and demand on a targeted family member to enter treatment, for example) and explicit coercion begins (Curtis & Diamond, 1997). Lutzen (1998) suggests that subtle coercion can be conceptualized as an interpersonal and dynamic activity, involving one

person (or several) exerting his or her will upon another" (p.103). O'Brien and Golding (2003) offer a broader definition proposing that coercion is ". . . any use of authority to override the choices of another" (p.168). Formal coercion usually has some form of external safeguards and oversight but the processes by which informal coercion is monitored and considered are usually much less clearly defined, if at all. In our discussion to follow for the sake of simplicity and clarity we subsume all the various definitions under the single term "coercion" to mean "any use of authority to override the choices of another," formal or informal, as defined by O'Brien and Golding, as it provides a broad enough definition to cover the various tactics employed by the helping professions to obtain compliance. It would seem that this important issue would warrant and encourage the wide critical examination of all forms of coercion used by social workers and the other helping professions. Unfortunately, that has not been the case up to the present.

The reality of social work's policing and behavioral control role has clearly been a source of discomfort if not embarrassment in the field, as it appears to clash with the profession's expressed humanitarian and ethical commitments to empower and educate the groups it seeks to help. As Davis (2002) notes:

> "The tension between self-determination and coercion, civil rights and paternalism, is ever present. However, while clinicians may be aware of this ethical dilemma, it has been this author's experience that serious discussions among colleagues about issues such as coercion and empowerment are rare." (p. 239)

Social Work Ethics

As we have described, the profession's long-standing objectives of trying to simultaneously promote autonomous and responsible behavior, aid the needy and vulnerable, and ensure the

safety and well-being of society (Hutchinson, 1992, p. 121) have caused persistent ethical tensions (see Reamer, 1983). The most notable attempt at addressing these ethical conflicts, particularly surrounding issues of coercion, has been through the development of formal ethical standards (Reamer, 2014, p. 170). In the United States the National Association of Social Workers (NASW) Code of Ethics (2008) is the most visible set of professional standards. This code, which has existed in various forms since 1960, has sought to guide social workers in their professional practice.

Despite its wide dissemination and promotion, the code does not resolve any ethical dilemmas or offer an effective protocol regarding the appropriate use of coercion. When "principles collide," practitioners are offered no help for properly moving forward except to rely on "professional" judgement (Reid, Floyd, & Bryan, 2010), a point the code itself acknowledges:

> "[T]he NASW Code of Ethics does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict." (NASW, 2008, para. 8)

This dilemma is further illustrated in section 1.01 of the current code, which states that:

> "Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised." (Section 1.01, para. 1)

So the well-being and autonomy of clients (as they themselves define well-being) can be superseded, according to the Code of Ethics, by the social worker's alternative view of well-being or competing professional responsibilities or both. This can lead to subsequent coercive actions toward the client, even when no criminal activity is being contemplated by the client,

such as when a client is considering suicide (even though in many states in the United States there are no requirements to report such behavior but only an option; see for example: National Conference of State Legislatures, 2015). The issue of suicide is a complex, but rarely discussed, issue in social work academia, outside of the presumption that a person contemplating it is severely disturbed and must be "prevented" from such actions even if the effort is coercive (for an alternate view see Gomory, 1997; Szasz, 1999).

Recent scholars (e.g., Bryan, 2006; Bryan, Sanders, & Kaplan, 2016) have argued that the Code of Ethics promotes conflicting moral principles and relies on incompatible moral theories (i.e., deontological and utilitarian perspectives). These authors have sought to reformulate the issue by appealing to the common morality model of ethical decision making. This model, originally developed by the bioethicist Bernard Gert (2004), describes a system of ethics grounded in everyday experiences. In doing so, it attempts to aid social workers in *identifying* ethical dilemmas through its delineation of ten moral rules (e.g., do not kill, do not deprive of freedom). These rules, it is argued, are to be followed to ensure ethical behavior. Circumstances where such rules are broken (e.g., involuntary hospitalization of a client) must be justified with respect to a two-step *adjudication* procedure, which consists of a) identifying the morally relevant features of the situation (e.g., identification of the rule being violated, and alternative actions, aside from violating one of the ten rules); b) asking whether anyone would be permitted to violate such a rule; and c) evaluating the consequences if it were the case that everyone knew that such a rule could be violated in that particular situation (see Bryan et al., 2016, pp. 40–46). In other words, following the ten rules ensures ethical behavior. It may be ethical to occasionally break one or more of these rules, but only with deference to the two-step decision-making process (pp. 40–46), which examines the ethical features of the issue and the consequences of violating such the rule under discussion. While this model offers a pragmatic alternative, which ostensibly avoids many of the problems

inherent in the Code of Ethics (e.g., reliance on grand ethical theory, or opposing professional duties), it too has not satisfactorily resolved social work's quandary with coercion. As Dunleavy, 2016 argues, the common morality model's ten rules rest on a problematic conception of rationality and its two-step adjudication procedure relies on a form of *rule-consequentialism* (in this case *utilitarianism*) that the model's creators denounce in their criticisms of the Code of Ethics (Bryan et al., 2016).

It is with these unresolved conceptual and pragmatic challenges in mind that we now turn to the three important domains of social work practice discussed earlier. But before delving into each individual area, we will comment briefly on the use of risk assessments. Risk assessments are commonly used to justify many different forms of coercive intervention, but their utility is only as legitimate as their ability to reliably and validly capture the intended behavioral phenomenon. In each individual section that follows our discussion of risk assessment, we will provide a brief overview of the types of coercive practices found within the area of practice, ethical arguments for and against their use, and an evaluation of the available evidence on their effectiveness. We conclude with some suggestions for the future of the profession, as well as for practitioners currently working in the field.

The Role of Risk Assessment

Most if not all coercive interventions by helping professionals, at least theoretically, are based on the assumption that we can accurately assess harmful actions such as individual violence, self-harm, and sexual and physical abuse, and can therefore prevent injury or death. Claiming to be experts at such assessments is what permits the helping professions including social work to be deputized to employ force that is usually reserved to the police. How valid is this assumption empirically? The latest research tells us not very. A recent 2012 *BMJ* meta-

analysis on assessing various troubling human behaviors directly relevant to social workers using a sample of 24,827 people finds:

> "[E]ven after 30 years of development, the view that violence, sexual, or criminal risk can be predicted in most cases is not evidence based. This message is important for the general public, media, and some administrations who may have unrealistic expectations of risk prediction for clinicians." (Fazel, Singh, Doll, & Grann, 2012, p. 5)

Another study (Large, Ryan, & Nielssen, 2011) on assessment for inpatient suicide found:

> "The existing models for assessing whether inpatients are at high risk of suicide all include one or more factors that were not found to be associated with inpatient suicide by meta-analysis and were probably chance associations. Using these risk factors to classify patients as being at high or low risk would prevent few, if any, suicides, and would come at a considerable cost in terms of more restrictive care of many patients and the reduced level of care available to the remaining patients. Risk categorization of individual patients has no role to play in preventing the suicide of psychiatric inpatients." (p. 507).

Finally, in child welfare things are equally bleak. Richard Gelles, Dean of the School of Social Policy and Practice at the University of Pennsylvania, in a 2011 CNN opinion piece reports:

> "The toolbox that child protective services employs in decision-making is alarmingly devoid of reliable and substantial tools. The main tools used to make decisions are either clinical judgment or risk-assessment instruments with little scientific accuracy." (Gelles, 2011, par. 10)

With Aron Shlonsky and Dennis Wagner, two prominent child welfare researchers, reporting that no forms of risk assessment

> "[A]ssist in case specific clinical decisions, nor does it engage the family in cooperative case planning, assess their functioning, establish case plan goals, or choose . . . interventions, nor would the predictive elements of consensus or clinical assessment." (2005, p. 421).

In fact, it appears that the latest computer-based algorithm (an approach touted to be far more scientifically "objective" when compared to assessments based on personal judgment of experts) developed to specifically identify future violent criminal behavior by current defendants fails to accurately predict such future behavior and is negatively biased against black defendants. ProPublica reports:

> "The score proved remarkably unreliable in forecasting violent crime: Only 20 percent of the people predicted to commit violent crimes actually went on to do so. . . . We also turned up significant racial disparities. . . . In forecasting who would re-offend, the algorithm made mistakes with black and white defendants at roughly the same rate but in very different ways. The formula was particularly likely to falsely flag black defendants as future criminals, wrongly labeling them this way at almost twice the rate as white defendants. White defendants were mislabeled as low risk more often than black defendants. (Angwin, Larson, Mattu, & Kirchner, 2016)

These conclusions leave us empirically adrift as to how professionals can accurately *predict* the potential for those future *individual* behaviors which, through various laws and policies, are deemed appropriate for coercive interventions. The simple facts are that using statistical analytic methodology we can only get reports on group average outcomes about researcher-constructed "risk" factors hypothesized to be relevant through prior research in particular

samples about the problem of interest. This methodology cannot offer a causal method for the accurate predictions of future *individual* behavior of persons not in the original research sample (see broadly Lange, 2008). This is the case because we do not know how to correctly insert that particular person into any of the so-called risk groups along the normal curve identified by prior research. An individual's future volitional behavior is completely open and causally unpredictable (Gomory, 2013).

Bearing this serious gap in our technical toolbox in mind let's next examine what sort of coercion we employ, the ethical arguments or justifications or both pro and con for their use, and finally what the latest research suggests about its effectiveness or drawbacks in child welfare, mental health, and addictions work. In doing so, it is important to keep in mind the reciprocal relationship between ethical arguments and the evidence used to support coercive intervention. Ethical arguments favoring the use of coercion cannot be justified without empirical support for the value of its deployment for the well-being of the coerced individual or society. One's rationale or "good" intention for coercing isn't alone enough to justify its use, if the action cannot be shown to be also effective, beneficial, helpful, etc. Similarly, empirical evidence does not *ipso facto* justify the use of a coercive action. While empirical evidence showing a coercive action's effect is necessary, it is not sufficient in and of itself to justify its use. Moral arguments are required to direct and constrain the use of coercion; so that it is invoked only when absolutely necessary and toward its "proper" use.

Coercion in Practice

Child Welfare

Child welfare workers are routinely faced with competing obligations to the individuals and families served and to society at large. Coercion related to child well-being typically is enforced when societal interests are believed to override or come in conflict with those of the parents or guardians, as it pertains to parental care. For example, coercive practices such as mandated reporting of child abuse or neglect; removal of a child from their guardians' home (facilitated by child welfare worker reporting); supervised visitation; and court-mandated parenting courses are commonly used in response to (Alvarez et al., 2005), or in an effort to prevent (Munro, 2009), obvious or potential child abuse (physical, sexual, or emotional) or neglect. While the scope of intrusive social work intervention in family life has arguably increased, coercive practices (as described above) have existed throughout the profession's history; beginning with the proliferation of nongovernmental child protection agencies throughout the early 1900s (Hancock & Pelton, 1989) and more recently in the United States with the increasing use of state-based child protective services from the 1960s onward (Myers, 2008). To justify the use of coercion interventions in the area of child welfare, several ethical and empirical arguments have been made.

Ethical arguments for and against coercion. While coercive intervention in response to child maltreatment is relatively uncontroversial in principle, the topic is not without debate. It is recognized that state-sanctioned police powers of child welfare organizations play an important role in ensuring children's safety in a placement or their home, even if they create a power imbalance between social worker and the parent or guardian. Coercive authority, according to some authors, is essential; its absence, "[R]enders the child maltreatment investigation powerless in the face of parental opposition if agents of the state were not imbued with the power to coerce when necessary, so that there may be an effective assessment of the circumstances of a child" (Pollack, MacKay, & Shipp, 2015, p. 169). When successfully deployed, coercive interventions are able to end child mistreatment and secure

appropriate services. However, when deployed without sufficient reason or with questionable empirical support, coercive interventions may lead to harmful or unjust consequences for the parent and child. According to this point of view, coercive interventions become more justifiable the more evidence there is to support their potential necessity for doing more good than harm for the at-risk children. For example, the policy of mandated reporting may be ethically permissible given sufficient empirical evidence to act, but would be contentious if implemented solely based on emotional, political, or ideological arguments, rather than available facts. Melton (2005) notes that all 50 of the United States-implemented mandated reporting laws within three years of Henry Kempe's popularization of "battered child syndrome," (p. 10), despite a dearth of information, at the time, on the practice's effectiveness in preventing harm.

Assessing the research. As noted earlier, risk assessments are problematic and fallible tools. However, social workers in child welfare routinely rely on risk assessment instruments in order to determine whether a child should be removed from a home. Despite their prevalence and occasionally mandated use during the initial investigation (Tower, 2009), child welfare risk assessment measures have come under significant scrutiny. Social worker Leroy Pelton (2008) notes that risk assessments can commonly identify stereotypes that may not in themselves constitute neglect or maltreatment (p. 30)—that is, generalizations about group identity of certain socioeconomically disadvantaged groups may lead to the identification of stereotypical characteristics or lifestyles (e.g. about poverty, drug or alcohol use, or the presence of nontraditional household residents, such as "live-in" boyfriends), which may reflect conventional presuppositions about what is socially acceptable behavior. But these characteristics or conditions may not directly translate into identifying, simply by their mere presence, parental or guardian abuse or neglect (p. 31). For example, a "dirty home" or the mere presence of illicit drugs may be used in some risk assessments as strong

indicators of potential risk. However, if there is no context provided to describe in what way such conditions contribute to the neglect or harm of the child, then decisions about the child's welfare may be made more on the basis of preconceived mainstream notions about the acceptable conditions of a "proper" home, and less about the actual effects of such conditions on the well-being of the child. Put another way, poorly developed risk assessments may mistakenly indicate the presence of "risk" through the identification of stigmatized or stereotypical behaviors without context which shows that, in and of themselves, they are not necessarily harmful. Furthermore, even "properly" designed assessment instruments may be liable to be misused.

Social workers, like all people, are subject to psychological and cognitive biases that may affect their professional judgment. Munro (1999) points out that when completing risk assessment measures, social workers may rely on a narrow range of evidence, which can lead to inaccurate or unreliable conclusions. Gambrill (2008) makes a similar point, noting that numerous personal biases affect individual judgments, including confirmatory bias, which identifies people's tendency to favor evidence that supports their underlying assumptions and expectations and minimize or ignore contradictory evidence. In a vignette study, Spratt, Devaney, and Hayes (2015) suggest that social workers commonly interpreted salient information about child removal and reunification in accordance with their preexisting beliefs about the needs of the child presented in the vignette. Consequently, social workers in the study recommended actions about whether or not the child should be reunified with their family in accordance with these preferences and beliefs. It is clear that though risk assessments may sometimes aid in identifying possible neglect or abuse, their use is greatly compromised by the well-established presence of personal prejudices and cognitive biases that factor into their administration.

Other issues concerning coercion deal with the power dynamics involved in client-worker relationships. It has been noted in the social work literature that child welfare workers often assume conflicting roles simultaneously; for example, those of mandated reporter, linker to welfare services, and provider of family advocacy and support (see Bundy-Faziola, Briar-Lawson, & Hardiman, 2009, p. 1456). These various responsibilities can often engender conflicting alliances among the various parties, leaving parents and guardians suspicious and feeling powerless. This often can result in complicating or preventing the building of a trusting and open partnership with the worker (Bundy-Faziola et al., 2009, p. 1458). The successful management of these role conflicts appears to be highly dependent on the social worker's approach and attitude. Platt (2008) found, based on interviews of both social workers and parents involved in the investigations of alleged child abuse, that rather than focusing solely on the more coercive, statutory child protection and social control role often assumed by social workers in child welfare, the use of caring strategies (e.g., the use of warmth and empathy and fully engaging the family in the assessment and planning process) maximized the potential for partnership with parents. Utilizing practices emphasizing honesty, openness, and sensitivity more effectively build partnerships with parents, while maintaining "awareness of the need to manage risk" (p. 302).

Mental Health

Involuntary mental health treatment is predicated on the notion that mental illnesses are "illnesses like any other," meaning that they are believed to have a biological basis, which may be amenable to physical interventions (e.g., psychiatric drugs—see Malla, Joober, & Garcia, 2015). Although grounds for involuntary treatment vary from state to state (in the United States) and country to country (in Europe and abroad), the decision to involuntarily hospitalize or treat a person is often based on one or more of the following assumptions: a)

That the person lacks insight into their condition (commonly referred to as anosognosia—see Marley, 2007); b) That treatment absence or refusal of treatment will result in mental and physical deterioration (see Applebaum & Gutheil, 1979); and c) That involuntary treatment may prevent a person from harming themselves or others (Sjöstrand, Sandman, Karlsson, Helgesson, Eriksson, & Juth, 2015).

Forms of coercion used by social workers, psychiatrists, and other mental health practitioners includes the use of or initiation of involuntary medication; involuntary commitment or hospitalization (Taylor, 2005); financial leveraging (i.e., acting as a patient's financial representative or payee—see Applebaum & Redlich, 2006); the use of physical restraints or seclusion practices (Holmes, Murray, & Knack, 2015); and the provision of services to clients who are in treatment against their will (among other practices). In what follows, we will examine the main ethical arguments for and against coercive mental health practices and examine the research surrounding involuntary treatment.

Ethical arguments for and against coercion. The ethical arguments substantiating the use of coercive or involuntary mental health practices are routinely informed by the medical model of mental illness, described above. In many ways, this is exemplified by the work of psychiatrist E Fuller Torrey, perhaps one of the most vocal advocates for involuntary treatment in the United States. From this perspective, involuntary treatment is a necessity due to the purported "lack of insight" commonly ascribed to those diagnosed as having a severe mental disorder (Torrey & Zdanowicz, 2001). Involuntary treatment, it is argued, ensures psychiatric medication compliance for those who would otherwise be at risk for homelessness, incarceration in the criminal justice system, suicide, or other acts of degeneration (p. 341). In other words, involuntary treatment can be argued to be justified on three accounts: a) the safety of the person diagnosed, b) the safety of others, and c) the need to treat a medical condition.

The view described above may be contrasted most sharply with that of some psychiatrists (Leifer, 2001; Szasz, 1961, 1997) and some social work academics (Kirk et al., 2013) who argue that involuntary commitment and treatment on the grounds of mental health is never appropriate since the problems encapsulated within the mental illness label are not medical diseases but lesser and more difficult problems in living (Szasz, 1961). It is argued that the medical model of mental illness provides a cover for the employment of otherwise unacceptable police power on a generally noncriminal set of troubled or troubling persons in need of societally perceived behavioral control by invalidating the claims of mentally ill clients when they disagree with the assessment of mental health experts whose opinions are simply assumed to be correct (Gomory et al., 2014). For example, when such individuals claim to be hearing voices, mental health workers accept that as fact because it validates their medical model view, but when clients would like to stop taking the prescribed drugs they are labeled as "denying their illness"—even though the effectiveness of these psychiatric drugs is highly questionable (Kirk et al., 2013)—because accepting these claims would undermine their authority and their right to coerce. Gomory et al. (2014) go on to argue that helping has to be explicitly separated from harming (locking up and forcing unwanted interventions on otherwise innocent individuals). In order to evaluate these very different perspectives of providing effective help to this group of troubled individuals, reviewing the empirical research is useful.

Assessing the research.

Epidemiology. Perhaps the first fact to note is that in 1961, 527,500 people resided as inmates in state and county mental hospitals in the United States (Scull, 1976, p. 176). Including the latter, fewer than one million people were diagnosed mental patients using psychiatric services in any sorts of public mental health facilities (Grob, 1994, p. 248). Fifty years later,

the National Institute of Mental Health (2011) declared that "[M]ental disorders are common in the United States. . . . An estimated 26.2 percent of Americans ages 18 and older . . . suffer from a diagnosable mental disorder in a given year . . . this figure translates to 57.7 million people." The NIMH further specifies that about 6 percent (3.5 million people) of those individuals are diagnosable with a "major mental illness." About four million individuals are subject to involuntary interventions each year (Kirk, , et al, 2013)

This amazing epidemiological increase in psychiatric diagnoses has occurred despite, or in tandem with, the increase in the number of mental health professionals, treatment centers, and funds devoted to preventing or treating mental illness. In 2010 in the United States, there were approximately 40,000 psychiatrists, 174,000 psychologists, and 255,000 clinical social workers (U.S. Bureau of Labor Statistics, 2010) dealing with mental health issues. The federal government has increased its funding for NIMH (2011) from $0.3 billion in 1986 to $1.5 billion in 2010 (most of it spent on research about treatments for the "seriously mentally ill"), making that agency the seventh highest funded of the 27 institutes and centers that comprise the National Institutes of Health (NIH). In 2005, year of the latest comprehensive national figures available for mental health service expenditures, the total national private and public expenditures for mental health services were approximately $113 billion—about 60 percent of it coming from tax revenues (Garfield, 2011). Apparently over 50 years of viewing madness as a medical problem with the routine use of involuntary interventions supposedly for the benefit of the client and billions of dollars expended for treatment and research the result is not any reduction of mental illness but exactly the opposite: a dramatic increase of those found to be diagnosable from one in approximately 184 adults in 1961 to 1 in 5 adult Americans today, perhaps verifying the harmful iatrogenic effects of the psychiatric medical model widely utilized by mental health workers, including the clinical social workers providing the majority of mental health services (Gomory, et al., 2011).

Involuntary treatment in the community. Compulsory treatment orders are now being employed in many jurisdictions in the United States and other countries, with more than half the states in the United States using these orders (Kisely & Campbell, & Preston, 2014) with the understanding that these are effective ways to deliver mental health treatment. However, the most recent systematic review conducted by the Cochrane Organization found it very much otherwise, concluding:

> "Based on results from this review, there is no strong evidence to support the claims made for compulsory community treatment that make it so attractive for legislators. It does not appear to reduce health service use or improve patients' social functioning. It also does not significantly reduce perceived coercion. Lack of data made it impossible to assess its effect on costs, mental state, and other aspects of patient/carer satisfaction." (Kisely, et al., 2014, p. 21).

Rugkasa, Dawson, and Burns (2014), leading researchers on the use of CTOs, offer an even more grim assessment. In their literature review of available RCTs, the authors state that:

> "The rationales for introducing CTOs . . . to reduce repeated relapses and to provide a less restrictive alternative to hospital[ization] . . . have a long history and their strengths are well argued. The weight of empirical evidence, however, is against them." (p. 1869)

and

> "If clinicians are to take a strictly evidence-based approach, then they cannot continue to use TOs in their current form." (p. 1869)

As to involuntary hospitalization the research is not much more encouraging:

The treatment of suicidal behavior. The only rationale for locking people up (involuntary hospitalization) and mandating the taking of powerful and highly toxic

psychiatric drugs with adverse effects on clients such as tardive dyskinesia, sexual dysfunction, obesity, diabetes, and heart disease (see Kirk, et al., 2013) is that such approaches ameliorate the problem. The latest data shows the opposite. Suicide in the United States has increased 24 percent since 1999, and according to a Center for Disease Control scientist, Deborah Stone, we don't have a clue why. "This increase is puzzling and troubling. Despite increased suicide prevention efforts, rates are rising" (Reinberg, 2016). The simple if stark facts generally recognized are that "given our present knowledge, even among high-risk samples of patients admitted to hospital for mental illness, it is not possible to predict suicide with *any* degree of accuracy" (Paris, 2006, p. 235, emphasis added), and regarding its prevention "[I]t has not been shown that we have any consistent way of preventing these fatal outcomes for most people at risk" (p. 237).

The available evidence shows little if any therapeutic value in involuntary approaches for addressing suicide or any other mental health issue, negating any credible rationale for its continued use. This finding will require social workers to reconsider their response to disturbed or disturbing behaviors through force, especially given evidence suggesting that minority groups (e.g., black Caribbean men and black African women in the United Kingdom) are disproportionately detained and hospitalized (see Mann et al., 2014).

Addictions

Both recreational and habitual drug users are liable to experience coercive practices as a result of their drug use. Coercive practices for drug misuse can be introduced in a variety of ways, and are not dependent on the legal status (i.e., licit or illicit distinction) of the drug being used. Rather involuntary commitment and treatment procedures (common in many Western countries) are often predicated on the assessment of possible harm to self or others (Nace et al., 2007) or as a result of user contact with the criminal justice system (Chandler,

2014). Although legal coercion of drug users does occur as a result of criminal behavior, we will primarily be concerned here with the purported "therapeutic" use of coercion, in contrast with punitive measures utilized for disciplinary reasons. Furthermore, although not discussed in detail here, punitive uses of coercion, as it pertains to drug use or possession or both, deserve greater professional and societal attention, as racial minority drug users (e.g., of marijuana and crack cocaine) are commonly discriminated against within the United States legal system, particularly through lengthier incarceration time (Hart, 2017; see also Alexander, 2010). Because drug users commonly come into contact with the law-enforcement apparatus, however, coercion driven by contact with the legal system remains a salient feature of our discussion.

Coercion as a treatment for drug use can come in many forms. These practices include: civil commitment initiated by law enforcement, treatment providers (social workers, psychiatrists, and other licensed professionals), and judges; involuntary inpatient (e.g., therapeutic communities) or outpatient treatment; community surveillance; attendance of 12-step (e.g. Alcoholics Anonymous) or other "fellowship" based programs; mandated attendance to psychoeducational or drug-court groups; drug "urinalysis" screening (Peters & Young, 2011); and pressure to comply with recommended pharmacological intervention (e.g., methadone, buprenorphine, disulfiram [Antabuse], etc.—see Chandler, 2014). Although some of these practices have been used historically, there has been an increasing shift away from categorizing them as punitive practices (see broadly Alexander, 1990 and Conrad & Schneider, 1992), and a push toward their biomedicalization as therapeutic "treatments" (see Davidson & Campbell, 2007), discussed further below.

Ethical arguments for and against coercion. The use of coercive practices has increasingly been justified on the basis that they are "medical" interventions and that drug users are "addicted" and in need of treatment. This despite having "no universally agreed

upon definition of [the term] addiction" in the scientific literature (Buchman, Illes, & Reiner, 2011, p. 65). For instance, the U.S. National Institute of Drug Abuse (NIDA) in their *Principles of Drug Abuse Treatment for Criminal Populations*, notes that drug addiction is a "chronic" (p. 21) "brain disease" (p. 1), and that legally mandated treatment can lead to "higher attendance rates" than for those who enter treatment without legal pressure (p. 18). The view of "addiction" as "brain disease" is vocally promoted by leaders in the substance abuse field (see Baler & Volkow, 2006; Volkow & Fowler, 2000), but that assertion's wide uncritical public acceptance has not been matched by the scientific research (Deacon, 2013; Foddy & Savulescu, 2010, pp. 3–9). Some researchers have pointed out the very variable course of addictive behaviors (findings which contradict the designation of addiction as a "chronic" disorder—see Heyman, 2001). Others have found no confirmatory neuroimaging brain lesions or biological markers to suggest a neurobiological explanation or pathology of addictive behavior(s) (Hall, Carter, & Forlini, 2015). While drug use may impair cognitive functioning, coercive practices predicated on the basis of "treating" a brain disease are at a minimum highly problematic.

Advocates of coercive practices might consider forced treatment necessary, even if it is not based on a "medical" model of drug use. In this respect, advocates may continue to maintain that coercion is justified in order to prevent harm to self or others, based on the presumption that the drug using individual has lost "self-control" or lacks "sound judgment". Kleinig notes that:

> "[I]t cannot be presumed that because a person constitutes a danger to himself or others he is unable to take responsibility for the choices he makes. The capacity to take responsibility for one's choices needs to be *independently* established. Even though it may seem odd that a person would willingly choose

> a course likely to be detrimental to himself, we should not see such irrational choice as inherently responsibility-defeating." (2004, p. 381, emphasis added)

and

> "[T]he judgment that a person constitutes a sufficiently significant danger to himself or others such that some intervention is justified is often highly speculative. We are not good predictors of dangerousness, and at least with respect to dangerousness to self, should be very reluctant to intervene." (p. 381)

Finally, the ethical argument against coercion may be made on the grounds that drug users have a right to control their own bodies. The philosopher Michael Huemer makes the case that drug use (absent direct harm toward others [e.g., violence]) is an exemplary case of self-determined behavior. He notes:

> "Drug use seems to be a paradigm case of a legitimate exercise of the right to control one's own body. Drug consumption takes place in and immediately around the user's own body; the salient effects occur inside the user's body. If we consider drug use merely as altering the user's own body and mind, it is hard to see how anyone who believes in rights at all could deny that it is protected by a right." (2009, p. 231).

Assessing the research. In an analysis of 618 methadone maintenance users, Brecht, Anglin, and Wang (1993) found similar improvements in narcotics use and criminal activity, regardless of whether the subjects had experienced low, moderate, or high levels of coercion as part of receiving treatment, with "level of coercion" defined as the extent of the participant's legal supervision, pressure to enter treatment, and frequency of drug testing. In a later study using interview data from 350 clients receiving treatment for methamphetamine abuse, Brecht, Anglin, and Dylan (2005) found that when treatment and client outcomes were

controlled for, odds of relapse were 1.7 times greater for those who were reported as experiencing legal pressure vs. those who did not report any legal pressure. Additionally, the authors found no significant differences in outcomes related to treatment completion between the two groups.

Klag, O'Callaghan, and Creed (2005) reviewed thirty years of research on legally coerced treatment of substance abusers and remarked that there is a "regrettable" dearth of "systematic and empirical research" to inform such practices (p. 1786). They, like others (Urbanowski, 2010) note that there is also very little information about how the coerced individual experiences the various pressures and forces acting upon them (Klag et al. 2005). However, a recent (2008) meta-analysis of the effectiveness of coercive treatment containing 129 studies of which nearly 40 percent focused on substance abuse treatment found, "that mandated treatment was ineffective, particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effect sizes regardless of setting" (Parhar, Wormith, Derkzen & Beauregard, p. 1128).

The implications of using coercion are significant. As we have noted in the preceding paragraph, treatment given coercively may be harmful rather than helpful. However, treatment found to be ineffective imposed by force may not only make no positive difference but also turn out to be harmful. A 1997 study of US prisons found that 16 percent of state prisoners (approximately 167,800 prisoners) had received some form of self-help group or peer group participation since their date of incarceration, compared with nearly 10 percent of Federal prisoners (approximately 7,894 prisoners—see U.S. Department of Justice, 1999, p. 10). These types of groups commonly contain elements of the 12-step model (e.g., Alcoholics Anonymous—see Taxman, Perdoni, & Harrison, 2007), an intervention that has come under increasing empirical criticism (Dodes & Dodes, 2014). That such a high number of offenders (not including the substantial number of offenders at the county and community level who are

mandated into treatment) are receiving an intervention with questionable efficacy (see also Schaler, 2000) is certainly contentious. An ineffective treatment provided coercively can cause significant iatrogenic harm, given that punitive measures often follow an offender's unsuccessful completion of a mandated treatment program (e.g., imprisonment).

Finally, growing attention is being paid to the importance of the therapeutic relationship (therapeutic alliance) during addiction treatment. In a popular social work textbook on substance abuse, McNeece and DiNitto (2005) point out the importance of considering the helping professional's personality in evaluating therapeutic effectiveness, noting that traits such as empathy and general helpfulness have been identified as possibly important features impacting client outcome (pp. 172–173); something worth considering with regard to the arguably confrontational and antagonistic relationship produced by the introduction of involuntary services. This focus on the helping relationship for successful helping efforts is supported by some of the latest empirical work on psychotherapy. In research evaluating the helping effort it has been found that psychosocial interventions or psychotherapies (e.g., cognitive behavioral therapy, interpersonal therapy, narrative therapy, 12-step programs) are not primarily driven by the "specific," unique mechanisms, practices, or protocols of each model but rather by shared "nonspecific" or common factors utilized in all of them (Asay & Lambert, 1999; Duncan et al., 2010), such as therapeutic alliance, therapist's competence, client commitment to the therapeutic process, and faith in the helper (Chatoor & Krupnick, 2001; Wampold & Imel, 2015).

Conclusion

Coercive approaches can be beneficial, state-sanctioned responses to particular social problems such as criminal activity. Placing adjudicated criminals in prison removes one

potential threat to society. However, when employed erroneously or when used without ethical and empirical justification, coercive actions may lead to harm and may even be considered a form of criminal behavior, analogous to assault or punishment. Given that social work continuously works with marginalized and disempowered groups, and given the profession's mandate to respect and support individual self-determination as social workers seek to help clients obtain their hoped-for outcomes, it is essential that the principled social worker addresses the complex topic of using coercion as part of their professional skillset. As we noted in our introduction, this is not merely an ethical imperative, but a professional one, impacting all social workers. This is particularly important given that coercive actions are often disproportionately employed with vulnerable groups, including racial and ethnic minorities and among women.

We have attempted here to give an overview of some of the ethical dilemmas surrounding social work's coercive practices as exemplified in three domains (child welfare, mental health, and addictions), and surveyed the empirical support for their use. Though we found coercive practices to be prevalent and sometimes a mandated part of social work professional practice, the available empirical evidence supporting their use turns out to be very weak and their superiority over voluntary interventions in rigorous studies nonexistent. We believe that the only credible use of forced treatment outside of the criminal justice system by the helping professions, especially for social work, should be if the coerced intervention is found to be more effective for the noncriminal client according to how she may want to be helped than alternate voluntary treatment, bearing in mind that even a demonstrable positive outcome of action must be obtained by the helping professional while adhering to generally accepted professional and societal ethical principles (i.e., personal change obtained through torture would not be acceptable). Otherwise, besides having to accept unwanted "treatment" (by definition these approaches are not seen as acceptable

voluntarily) the client may be learning, in addition, that being forced by social welfare service or medical professional authority to comply, even though they have done nothing criminal, is acceptable in a democracy. When social workers are engaged in coercive practices and tactics without good ethical and scientific reasons they are not helpers but harmers, police agents rather than humane service providers. Liberty and autonomy are hard-fought-for elements of our democratic way of life and a vital part of social work's historical commitment to helping our clients, but so is the well-documented role of social work as a profession enforcing state mandated social control (Gomory et al, 2011; Margolin, 1997).

Going forward, we need to engage in an honest, far-reaching, profession-wide and rigorous examination of the use of coercion as part of social work's professional technology that includes the role of our educational institutions and their impact on our students. First, this requires a much more honest admission of its widespread use and then a searching examination of what is the appropriate role of social work in the jurisdiction of "personal problems" that we've found ourselves a part of since the beginning of the 20th century along with the other helping professions (Abbott, 1988). This self-examination should include a critical discussion of admitted role conflicts we identified earlier of being both agents of the state while being considered agents of clients. We have our doubts about the viability of this dual agency. The old adage "He who pays the piper calls the tune" may be very apt here. Can the profession of social work receive funding from government—the largest source of support for the salaries of most social workers and the budgets of their agencies—for which in turn we are expected to follow governmental rules and regulations, such as the mandated interventions we have been examining in this article, and claim at the same time that we are unbiased agents for our clients, helping them become autonomous and "empowered" even when their hopes and expectations differ from the government regulations and protocols? Can we ethically reconcile coercing with caring as we move deeper into the 21st century? Or

should we consider discarding coercing because according the empirical literature its use does more harm than good?

We conclude by offering some suggestions for further reading about the topic of coercion, both broadly and within the three domains discussed here. We hope that this entry will stimulate social workers to think critically about coercion and that such a discussion contributes to the broader professional and societal discussion about the benefits and harms and advantages and limitations of coercive practices.

Further Reading

Cohen, S. (1988). *Against criminology*. New Brunswick, NJ: Transaction.

Cohen, S., & Scull, A. T. (Eds.). (1986). *Social control and the state: Historical and comparative essays.* Oxford: Oxford University Press.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalization: From badness to sickness* (2nd ed.). Philadelphia: Temple University Press.

Hari, J. (2015). *Chasing the scream: The first and last days of the war on drugs*. New York: Bloomsbury.

Kallert, T. W., Mezzich, J. E., & Monahan, J. (Eds.). (2011). *Coercive treatment in psychiatry: Clinical, legal and ethical aspects.* New York: John Wiley

Margolin, L. (1997). *Under the cover of kindness: The invention of social work.* Charlottesville: University of Virginia Press.

Murphy, J. (2015). *Illness or deviance? Drug courts, drug treatment, and the ambiguity of addiction*. Philadelphia: Temple University Press.

Reid, P. N., & Popple, P. R. (Eds.). (1992). *The moral purposes of social work: The character and intentions of a profession*. Chicago, IL: Nelson-Hall.

Rothman, D. J. (1990). *The discovery of the asylum: Social order and disorder in the new republic*. Boston: Little, Brown and Co.

Scull, A. T. (1977). *Decarceration: Community treatment and the deviant—A radical view*. Englewood Cliffs, NJ: Prentice-Hall.

Szasz, T. (2007). *Coercion as cure*. New Brunswick, NJ: Transaction.

Tiger, R. (2012). *Judging addicts: Drug courts and coercion in the justice system*. New York: New York University Press.

References

Abbott, A. (1988). *The system of professions*. Chicago: The University of Chicago Press.

Alexander, B. K. (1990). *Peaceful measures: Canada's way out of the "War on Drugs."* Toronto: University of Toronto Press.

Alexander, M. (2010). *The new Jim Crow: Mass incarceration in the age of colorblindness*. New York: The New Press.

Alvarez, K. M., Donohue, B., Kenny, M. C., Cavanagh, N., & Romero, V. (2005). The process and consequences of reporting child maltreatment: A brief overview for professionals in the mental health field. *Aggression and Violent Behavior, 10*(3), 311–331.

Anfang, S. A., & Applebaum, P. S. (2006). Civil commitment—The American experience. *The Israel Journal of Psychiatry and Related Sciences, 43*(3), 209–218.

Angwin, J., Larson, J., Mattu, S., & Kirchner, L. (2016, May 23). Machine bias. *ProPublica*. Retrieved from: https://www.propublica.org/article/machine-bias-risk-assessments-in-criminal-sentencing

Applebaum, P. S., & Gutheil, T. G. (1979). "Rotting with their rights on": Constitutional theory and clinical reality in drug refusal by psychiatric patients. *The Bulletin of the American Academy of Psychiatry and Law, 7*(3), 306–315.

Applebaum, P. S., & Redlich, A. (2006). Use of leverage over patients' money to promote adherence to psychiatric treatment. *The Journal of Nervous and Mental Disease, 194*(4), 294–302.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 23–55). Washington, DC: American Psychological Association.

Baler, R. D., & Volkow, N. D. (2006). Drug addiction: The neurobiology of disrupted self control. *Trends in Molecular Medicine, 12*(12), 559–566.

Brecht, M., Anglin, M. D., & Dylan, M. (2005). Coerced treatment for methamphetamine abuse: Differential patient characteristics and outcomes. *The American Journal of Drug and Alcohol Abuse*, *31*(2), 337–356.

Brecht, M., Anglin, M. D., & Wang, J. C. (1993). Treatment effectiveness for legally coerced versus voluntary methadone maintenance clients. *American Journal of Drug and Alcohol Abuse, 19*(1), 89–106.

Bryan, V. (2006). Moving from professionally specific ideals to the common morality: Essential content in social work education. *Journal of Teaching in Social Work, 26*(3–4), 1–17.

Bryan, V., Sanders, S., & Kaplan, L. (2016). *The helping professional's guide to ethics: A new perspective*. Chicago: Lyceum.

Buchman, D. Z., Illes, J., & Reiner, P. B. (2011). The paradox of addiction neuroscience. *Neuroethics, 4*(2), 65–77.

Bundy-Faziola, K., Briar-Lawson, K., & Hardiman, E. R. (2009). A qualitative examination of power between child welfare workers and parents. *British Journal of Social Work, 39*(8), 1447–1464.

Campbell, J., & Davidson, G. (2009). Coercion in the community: A situated approach to the examination of ethical challenges for mental health social workers. *Ethics and Social Welfare*, *3*(3), 249–263.

Campbell, J., & Davidson, G. (2012). *Post-qualifying mental health social work practice*. London: Sage.

Campbell, N. C. (1992). Medicalization and biomedicalization: Does the diseasing of addiction fit the frame? In J. Netherland (Ed.), *Critical Perspectives on Addiction* (pp. 3–25). Bingley, UK: Emerald.

Carpenter, J. (2002). Outpatient commitment for adults with psychiatric disabilities: Examining the underlying assumptions. *Families in Society*, *83*(3), 293–301.

Chandler, J. A. (2014). Legally-coerced consent to treatment in the criminal justice system. In D. Holmes, A. Perron, & J. D. Jacob (Eds.), *Power and the psychiatric apparatus: Repression, transformation, and assistance* (pp. 199–216). Burlington, VT: Ashgate.

Chatoor, I., & Krupnick, J. (2001). The role of non-specific factors in treatment outcome of psychotherapy studies. *European Child & Adolescent Psychiatry, 10* (supp. 1), 119–125.

Churchill, R., Owen, G., Singh, S., & Hotopf, M. (2007). *International experiences of using community treatment orders*. London: Institute of Psychiatry.

Cohen, S., & Scull, A. T. (Eds.) (1986). *Social control and the state: Historical and comparative essays.* Oxford: Oxford University Press.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalization: From badness to sickness* (2d ed.). Philadelphia: Temple University Press.

Curtis, L. C., & Diamond, R. (1997). Power and coercion in mental health practice. In B. Blackwell (Ed.), *Treatment compliance and the therapeutic alliance* (pp. 97–122), Amsterdam: Harwood Academic.

Davidson, G., Barry, L., Curry, P., Darragh, E., Duffy, J. & Lees, J. (2012). Championing the interface between mental health and child protection: Evaluation of a service initiative to improve joint working in Northern Ireland, *Child Abuse Review*, *21*(3), 157–172.

Davidson, G., & Campbell, J. (2007). An examination of the use of coercion by assertive outreach and community mental health teams in Northern Ireland. *British Journal of Social Work*, *37*(3), 537–555.

Davis, S. (2002). Autonomy versus coercion: Reconciling competing perspectives in community mental health. *Community Mental Health Journal, 38*(3), 239-250.

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846–861.

Dennis, D. L., & Monahan, J. (Eds.). (1996). *Coercion and aggressive community treatment*. New York: Plenum.

Dodes, L. & Dodes, Z. (2014). *The sober truth: Debunking the bad science behind 12-step programs and the rehab industry*. Boston, MA: Beacon.

Duncan, B. L., Miller, S.D., Wampold, B. E., & Hubble, M. A. (2010). *The heart & soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Dunleavy, D. J. (2016). Social work ethics in mental health. Oral presentation at the annual meeting of the *Council of Social Work Education*, November 3–6, 2016, Atlanta, GA.

Fazel, S., Singh, J. P., Doll, H., & Grann, M. (2012). Use of risk assessment instruments to predict violence and antisocial behavior in 73 sample involving 24,827 people: Systematic review and meta-analysis. *BMJ, 12*(345), 1–12.

Foddy, B., & Savulescu, J. (2010). A liberal account of addiction. *Philosophy, Psychiatry, & Psychology, 17*(1), 1–22.

Gambrill, E. (2008). Decision making in child welfare: Constraints and potentials. In D. Lindsey & Aron Schlonsky (Eds.), *Child welfare research: Advances for practice and policy* (pp. 175–193). New York: Oxford University Press.

Garfield, R. L. (2011). *Mental health financing in the United States: A primer*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

Gelles, R. J. (2011, February 18). Why did Fla. children slip through cracks? *CNN.* Retrieved from: http://www.cnn.com/2011/OPINION/02/18/gelles.florida.child.abuse/

Gert, B. (2004). *Common morality: Deciding what to do*. New York: Oxford University Press.

Goldstein, R. Z., & Volkow, N. D. (2011). Dysfunction of the prefrontal cortex in addiction: Neuroimaging findings and clinical implications. *Nature Reviews Neuroscience, 12*(1), 652–669.

Gomory, T. (1997). Does the goal of preventing suicide justify placing suicidal clients in care? No. In E. Gambrill & R. Pruger (Eds.), *Controversial issues in social work: Ethics, values, and obligations* (pp. 70–74). Boston: Allyn & Bacon.

Gomory, T. (1999). Programs of assertive community treatment (PACT): A critical review. *Ethical Human Sciences and Services, 1*(2), 147–163.

Gomory, T. (2005). Assertive community treatment (ACT): The case against the "best tested" evidence-based community treatment for severe mental illness. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives* (pp. 165–189), New York: Columbia University Press.

Gomory, T. (2013). The limits of evidence-based medicine and its application to mental health evidence-based practice: Part one. *Ethical Human Psychology and Psychiatry, 15*(1), 18–34.

Gomory, T., Cohen, D., & Kirk, S. A. (2014). Coercion: The only constant in psychiatric practice? In M. Dellwing, & M. Harbusch (Eds.), *Krankheitskonstrukti.und Krankheitstreiberei: Die Renaissance der soziologischen Psychiatriekritik* [*Disease constructions and disease mongering*] (pp. 289–312). Heidelberg, Germany: Springer.

Gomory, T., Wong, S. E., Cohen, D., & Lacasse, J. R. (2011). Clinical social work and the biomedical industrial complex. *Journal of Sociology and Social Welfare, 38*(5), 135–165.

Goroff, N. N. (2014). Social welfare as coercive social control. *The Journal of Sociology & Social Welfare, 2*(1), 19–26.

Grob, G. N. (1994). *The mad among us: A history of the care of America's mentally ill*. Cambridge, MA: Harvard University Press.

Hall, W., Carter, A., & Forlini, C. (2015). The brain disease model of addiction: Is it supported by the evidence and has it delivered on its promises? *Lancet Psychiatry, 2*(1), 105–110.

Hall, W., Farrell, M., & Carter, A. (2014). Compulsory treatment of addiction in the patient's best interests: More rigorous evaluations are essential. *Drug and Alcohol Review, 33*(3), 268–271.

Hancock, B. L., & Pelton, L. (1989). Home visits: History and functions. *Social Casework, 70*(1), 21–27.

Hart, C. L. (2017). Viewing addiction as a brain disease promotes social injustice. *Nature: Human Behavior, 1*, article: 0055. Retrieved from http://dx.doi.org/10.1038/s41562-017-0055

Health and Social Care Information Centre. (2012). *Inpatients formally detained in hospitals under the Mental Health Act 1983, and patients subject to supervised community treatment: Annual figures, England, 2011–2012*. *NHS Digital.* Retrieved from https://digital.nhs.uk/catalogue/PUB08085

Heyman, G. M. (2001). Is addiction a chronic, relapsing disease? Relapse rates, estimates of duration, and a theory of addiction. In P. Heymann & W. Brownsberger (Eds.), *Drug Addiction and Drug Policy* (pp. 81–117). Cambridge, MA: Harvard University Press.

Holmes, D., Murray, S. J., & Knack, N. (2015). Experiencing seclusion in a forensic psychiatric setting: A phenomenological study. *Journal of Forensic Nursing, 11*(4), 200–213.

Huemer, M. (2009). America's unjust drug war. In J. Rachels & S. Rachels (Eds.), *The right thing to do: Basic readings in moral philosophy* (5th ed.) (pp. 223–236). New York: McGraw Hill.

Hutchinson, E. D. (1992). Competing moral values and use of social work authority with involuntary clients. In P. N. Reid & P. R. Popple (Eds.), *The moral purposes of social work: The character and intentions of a profession* (pp. 120–140). Chicago: Nelson-Hall.

International Federation of Social Workers. (2016, March 25). *Statement of ethical principles*. Retrieved November 19, 2012 from: http://ifsw.org/policies/statement-of-ethical-principles/

Kallert, T. W., Mezzich, J. E., & Monahan, J. (Eds.). (2011). *Coercive treatment in psychiatry: Clinical, legal and ethical aspects.* New York: John Wiley & Sons.

Kirk, S. A., Gomory, T., & Cohen, D. (2013). *Mad science: Psychiatric coercion, diagnosis, and drugs*. Rutgers, NJ: Transaction.

Kisely, S. R. & Campbell, L. A. , & Preston, N. (201). Compulsory community and involuntary outpatient treatment for people with severe mental disorders. *Cochrane Database of Systematic Reviews, 2*(CD004408). doi: 10.1002/14651858.CD004408.pub3. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4164937/

Klag, S., O'Callaghan, F., & Creed, P. (2005). The use of legal coercion in the treatment of substance abusers: An overview and critical analysis of thirty years of research. *Substance Use & Misuse, 40*(12), 1777–1795.

Kleinig, J. (2004). Ethical issues in substance use intervention. *Substance Use & Misuse, 39*(3), 369–398.

Lange, M. (2008). Hume and the problem of induction. In D.M. Gabbay, P. Thagard, & J. Woods (Eds.), *Handbook of the History of Logic* (Vol. 10, pp. 43–91). Waltham, MA, North Holland.

Larcher, V. (2007). Ethical issues in child protection. *Clinical Ethics, 2*(4), 208–212.

Large, M., Ryan, C., & Nielssen, O. (2011). The validity and utility of risk assessment for inpatient suicide. *Australasian Psychiatry, 19*(6), 507–512.

Leifer, R. (2001). A critique of medical coercive psychiatry, and an invitation to dialogue. *Ethical Human Sciences and Services, 3*(3), 161–173.

Lutzen, K. (1998). Subtle coercion in psychiatric practice, *Journal of Psychiatric and Mental Health Nursing*, *5*(2), 101–107.

Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other illness": A critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry & Neuroscience, 40*(3), 147–150.

Mann, F., Fisher, H. L., Major, B., Lawrence, J., Tapfumaneyi, A., Joyce, J., . . . Johnson, S. (2014). Ethnic variations in compulsory detention and hospital admissions for psychosis across four UK early intervention services. *BMC Psychiatry, 14*(article 256). Retrieved from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-014-0256-1

Margolin, L. (1997). *Under the cover of kindness: The invention of social work*. Charlottesville: University of Virginia Press.

Marley, J. (2007). Anosognosia and schizophrenia: The ethical intersection of insight, treatment and coercion. *BMC Psychiatry, 7*(supp.1): S20. Retrieved from http://dx.doi.org/10.1186/1471-244X-7-S1-S20

McNeece, C. A. & DiNitto, D. M. (2005). *Chemical dependency: A systems approach* (3rd ed.). Boston: Allyn & Bacon.

Melton, G. B. (2005). Mandated reporting: A policy without reason. *Child Abuse & Neglect, 29*, 9–18.

Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*, 60–71.

Munro, E. (1999). Common errors of reasoning in child protection work. *Child Abuse & Neglect, 23*(8), 745–758.

Munro, E. (2007). Confidentiality in a preventive child welfare system. *Ethics and Social Welfare, 1*(1), 41–55.

Munro, E. (2009). Managing societal and institutional risk in child protection. *Risk Analysis, 29*(7), 1015–1023.

Myers, J. E. B. (2008). A short history of child protection in America. *Family Law Quarterly, 42*(3), 449–463.

Nace, E. P., Birkmayer, F., Sullivan, M. A., Galanter, M., Fromson, J. A., Frances, R. J., ... Westermeyer, J. (2007). Socially sanctioned coercion mechanisms for addiction treatment. *The American Journal of Addictions, 16*(1), 15–23.

National Association of Social Workers. (2017). Code of ethics of the National Association of Social Workers. *NASW*. Retrieved from: https://www.socialworkers.org/About/Ethics/Code-of-Ethics

National Conference of State Legislatures. (2015, September 28). Mental health professionals' duty to warn. *NCSL.* Retrieved from: http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx.

National Institute of Drug Abuse. ([2006] 2014). Principles of drug abuse: Treatment for criminal justice populations: A research-based guide. *NIH.* Retrieved from: https://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf

National Society for the Prevention of Cruelty to Children. (2012). *Statistics on looked after children. NSPCC.* Retrieved from https://www.nspcc.org.uk/preventing-abuse/child-protection-system/children-in-care/

National Society for the Prevention of Cruelty to Children. (2017). How safe are our children? The most comprehensive overview of child protection in the UK. NSPCC. Retrieved from: https://www.nspcc.org.uk/globalassets/documents/research-reports/how-safe-children-2017-report.pdf

O'Brien, A. J., & Golding, C. G. (2003). Coercion in mental healthcare: The principle of least coercive care. *Journal of Psychiatric and Mental Health Nursing, 10*, 167–173.

Paris, J. (2006). Predicting and preventing suicide: Do we know enough to do either? *Harvard Review of Psychiatry, 14*(5), 233–240.

Parhar, K. K., Wormith J. S., Derkzen, D. M., & Beauregard, A. M. (2008). Offender coercion in treatment: A meta-analysis of effectiveness. *Criminal Justice and Behavior, 35*(9), 1109–1135.

Peckham, M. (1979). *Explanation and power: The control of human behavior.* New York: Seabury.

Pelton, L. H. (2008). Informing child welfare: The promise and limits of empirical research. In D. Lindsey & A. Shlonsky (Eds.), *Child welfare research: Advances for practice and policy* (pp. 25–48). New York: Oxford University Press.

Pelton, L. H. (2015). Separating coercion from provision in child welfare: Preventing supports should be accessible without conditions attached. *Child Abuse and Neglect, 51*, 427–434.

Peters, R. H., & Young, S. (2011). Coerced drug treatment. In M. Kleinman, J. Hawdon, & G. Golson (Eds.), *Encyclopedia of Drug Policy*. Thousand Oaks, CA: SAGE.

Platt, D. (2008). Care or control? The effects of investigations and initial assessments on the social worker-parent relationship. *Journal of Social Work Practice, 22*(3), 301–315.

Pollack, D., MacKay, K., & Shipp, K. (2015). The use of coercion in the child maltreatment investigation field: A comparison of American and Scottish perspectives. *University of Miami International and Comparative Law Review, 22*, 129–170.

Popple, P. R. (1992). Social work: Social function and moral purpose. In P. N. Reid & P. R. Popple (Eds.), *The moral purposes of social work: The character and intentions of a profession* (pp. 141–154). Chicago: Nelson-Hall.

Reamer, F. G. (1983). The concept of paternalism in social work. *Social Service Review*, *57*(2), 254–271.

Reamer, F. G. (2014). The evolution of social work ethics: Bearing witness. *Advances in Social Work, 15*(1), 163–181.

Reid, C. E., Floyd, C. K., & Bryan, V. (2010). Social work, morally relevant properties and paternalism: Why social workers need to know moral theory. *Journal of Social Work Values and Ethics, 7*(2), 1–16.

Reid, P. N. (1992). The social function and social morality of social work: A utilitarian perspective. In P. N. Reid & P. R. Popple (Eds.), *The moral purposes of social work: The character and intentions of a profession* (pp. 34–50). Chicago: Nelson-Hall.

Reinberg, Steven. (2016, April 22). U.S. suicide rate up 24 percent since 1999: CDC. *WebMD*. Retrieved from: https://www.webmd.com/mental-health/news/20160422/us-suicide-rate-up-24-percent-since-1999-cdc#1

Rittner, B., & Dozier, C. D. (2000). Effects of court-ordered substance abuse treatment in child protective services cases, *Social Work, 45*(2), 131–140.

Rugkasa, J., Dawson, J., & Burns, T. (2014). CTOs: What is the state of the evidence? *Social Psychiatry and Psychiatric Epidemiology, 49*(12), 1861–1871.

Ryan, C., Nielsse, O., Paton, M., & Large, M. (2010). Clinical decisions in psychiatry should not be based on risk assessment. *Australasian Psychiatry, 18*(5), 398–403.

Satel, S., & Lilienfeld, S. O. (2014). Addiction and the brain-disease fallacy. *Frontiers in Psychiatry, 4*, 1–11.

Schaler, J. (2000). *Addiction is a choice*. Chicago: Open Court.

Scheyett, A., Kim, M., Swanson, J., Swartz, M., Elbogen, E., van Dorn, R., & Ferron, J. (2009). Autonomy and the use of directive intervention in the treatment of individuals with serious mental illnesses: A survey of social work practitioners. *Social Work in Mental Health, 7*(4), 283–306.

Scull, A. (1976). The decarceration of the mentally ill: A critical view. *Politics & Society, 6*(2), 173–212.

Shlonsky, A., & Wagner, D. (2005). The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management. *Child and Youth Services Review, 27*(4)*,* 409–427.

Sjöstrand, M., Sandman, L., Karlsson, P., Helgesson, G., Eriksson, S., & Juth, N. (2015). Ethical deliberations about involuntary treatment: Interviews with Swedish psychiatrists. *BMC Medical Ethics*, *16*(37), 1–12.

Spratt, T., Devaney, J., & Hayes, D. (2015). In and out of home care decisions: The influence of confirmation bias in developing decision supportive reasoning. *Child Abuse & Neglect, 49*, 76–85.

Stevens, A. (2012). The ethics and effectiveness of coerced treatment of people who use drugs. *Human Rights and Drugs*, *2*(1), 7–15.

Sullivan, M. A., Birkmayer, F., Boyarsky, B. K., Frances, R. J., Fromson, J. A., Galanter, M., … Westmeyer, J. (2008). Uses of coercion in addiction treatment: Clinical aspects. *The American Journal on Addictions, 17*(1), 36–47.

Szasz, T. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Paul B. Hoeber.

Szasz, T. (1997). The case against psychiatric coercion. *The Independent Review, 1*(4), 485–498.

Szasz, T. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport, CN: Praeger.

Taxman, F. S., Perdoni, M. L., & Harrison, L. D. (2007). Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment, 32*(3), 239–254.

Taylor, M. F. (2005). Social workers and involuntary treatment in mental health. *Advances in Social Work, 6*(2), 240–250.

Torrey, E. F., & Zdanowicz, M. (2001). Outpatient commitment: What, why, and for whom. *Psychiatric Services, 52*(3), 337–341.

Tower, J. M. (2009). Striking a better balance between child safety and parental rights. *Advocates' Forum*, 54–66. Retrieved from http://www.ssa.uchicago.edu/striking-better-balance-between-child-safety-and-parental-rights

United States Bureau of Labor Statistics. (2010). Occupational outlook handbook, 2010–2011 library edition. *U. S. Department of Labor.* Retrieved from: https://www.credentialwatch.org/occ/2010-11OOH.pdf.

Urbanowski, K. A. (2010). Coerced addiction treatment: Client perspectives and the implication of their neglect. *Harm Reduction Journal, 7*(1), 1–10.

U.S. Department of Justice. (1999). Substance abuse and treatment, state and federal prisoners, 1997. *Bureau of Justice Statistics.* Retrieved from: http://csdp.org/research/satsfp97.pdf

U.S. Department of Labor. (2016). Occupational outlook handbook, 2016–2017 edition: Social workers. *U.S. Department of Labor.* Retrieved from: http://www.bls.gov/ooh/community-and-social-service/social-workers.htm

Volkow, N. D., & Fowler, J. S. (2000). Addiction, a disease of compulsion and drive: Involvement of the orbitofrontal cortex. *Cerebral Cortex, 10*(3), 318–325.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York: Routledge.

Whitaker, T., and Arrington, P. (2008). *Social workers at work: NASW membership workforce study*. Washington, DC: National Association of Social Workers.

Wilson, M. (2010). *Criminal justice social work in the United States: Adapting to new challenges*. Washington, DC. NASW Center for Workforce Studies.

Zanni, G. R., & Stavis, P. F. (2007). The effectiveness and ethical justification of psychiatric outpatient commitment. *The American Journal of Bioethics, 7*(11), 31–41.

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