SOCIAL WORKERS AND INVOLUNTARY TREATMENT IN MENTAL HEALTH

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Abstract: *Involuntary treatment is often a reality in mental health social work. The current research examined 330 mental health social workers' involvement in and opinions about involuntary treatment as part of their primary job functions. Varieties of involuntary intervention and typical frequency were investigated. The most often cited areas of involuntary treatment experience proved to be mandated outpatient counseling and emergency hospitalization. In general, participants reported a high level of support for the existence of involuntary intervention, both in "idea" and "implementation." The study also explored the attitudes social workers have about these sometimes "ethically-complex" social work interventions and how these attitudes may have changed over the life of their practice careers due to practice experience and personal growth, job changes, and exposure to the reality of mental illness.*

Key Words: *Involuntary Treatment, mental health practice, ethical dilemmas*

BACKGROUND

Reamer (1995) has called social work "among the most value-based of all professions" (p.3). In such a value-rich atmosphere as mental health social work, all job tasks and interventions are, to some degree, infused with values and therefore have the potential for value collisions and professional dissonance (Taylor, 2002). Interventions characterized as "involuntary," however, may prove to be especially problematic for social workers in mental health since psychiatry has been called "virtually the only medical specialty that includes coerced, involuntary treatment" (Shore, 1997, p. 325). For the current study, involuntary treatment refers *to mandated services, both inpatient and outpatient, that are provided to consumers, often despite their wishes to the contrary.*

Social work and allied authors (Taylor & Bentley, 2004; Bentley & Taylor, 2002; Dewees, 2002; Kutchins & Kirk, 1997; Bentley, 1993) have pointed out the incongruity—and perhaps, incompatibility—between the increasing emphasis on involuntary treatment interventions and social work's historical stance and current Code of Ethics which allows for restriction of self-determination only when risk is "foreseeable and imminent" (NASW, 1997). Dewees (2002) urges social workers to recognize the "contestability" of the medical hegemony they have begun to accept as inevitable and points out the incompatibility of this medical dominance with social work's primary focus on strengths and empowerment. Other social work writers strongly disagree with this perceived incompatibility between social work values and involuntary or beneficent treatment interventions (Murdach, 1996; Rosenson, 1993) and cite the

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consumers' *right to treatment* as an important area for social work support, not just the *right to refuse treatment* (Mizrahi, 1992). Still others suggest that taking for and against positions in this debate distracts the mental health community from more important questions about the state of service delivery in the mental health arena (Saks, 2002).

Opinions aside, for many mental health practitioners using coercive and involuntary treatments has become part and parcel of their job duties. These practitioners may regularly hospitalize consumers under involuntary orders or facilitate court orders for medication and outpatient treatment. At the least, many practitioners are increasingly faced with negotiating difficult practice decisions with consumers who present for treatment under court mandate. A reflection of this phenomena is the expansion of content on involuntary practice in the fifth edition of Hepworth, Rooney and Larsen's (1997) *Direct social work practice: Theory and skills,* a classic social work practice text. While literature exists in the social work and allied fields around the issues of involuntary treatment and the stakeholders in its implementation (Motlong, 1997; Dennis & Monahan, 1996; Solomon, 1996; Wilk, 1994,1988a, 1988b; Abramson, 1991, 1989; Scheid-Cook, 1991), there has been less attention paid to the deliberations and trepidations that involuntary treatment creates in practitioners. The current study sought to explore what social workers think about involuntary treatment, what they do in "real-life practice" situations and how both of these things have changed over the course of their practice lives. A goal of the study was to add to the knowledge base of social work practice with persons who have serious mental illness and the nature of involuntary services delivery.

METHODOLOGY

Sample. A systematic random sampling technique was used to recruit 750 participants who were listed in the *Register of Clinical Social Workers, 11th Edition* (NASW, 2001). The National Association of Social Workers (NASW), the professional organization that publishes the *Register,* is the largest professional social work organization with 155,000 members (Gibelman & Schervish, 1997). A total of 320 usable surveys were returned which related to a response rate of 44.4%.

Instrumentation. An instrument was created for the purposes of this study. Copies of the instrument can be obtained from the author. The instrument covered three areas: involuntary treatment, self-determination and professional dissonance (the feeling state that occurs when values and job tasks conflict). Only the results of the involuntary treatment portion of the instrument are described here. Two series of seven questions explored both participants' exposure to and comfort with, specific involuntary tasks. Four of these seven questions concerned seeking or facilitating an order for involuntary inpatient or outpatient commitment, or involuntary medication. The other three questions concerned actually providing mandated inpatient or outpatient psychiatric and substance abuse services. Participants first indicated their level of comfort in providing the seven services, using a Likert-type scale ranging from "totally uncomfortable" to "totally comfortable." Two items directed participants to rate their level of agreement with involuntary treatment both in theory and in implementation and their comfort level over time with involuntary treatment. Participants were invited

to write a few words about how their comfort level has changed over the years of their practice. A final question was completely open-ended inviting participants to share "anything else" about involuntary treatment.

The instrument was pilot-tested with an interdisciplinary group of mental health professionals working in the psychiatric pavilion of a large medical center. The four professionals were asked to answer the items and identify any that were unclear or problematic. A panel of seasoned social work researchers also reviewed the instrument prior to data collection.

Data analysis. Data from the Likert-type items was coded and analyzed using the SPSS-10 statistical package. Data from the open-ended questions were typed verbatim into corresponding individual data files, separated by question number and labeled with their respective participant identification numbers. The researcher printed one copy. An open-coding technique was utilized in order to identify patterns in the responses (Strauss & Corbin, 1998). From these patterns, categories and subcategories were identified to group the responses through the use of key words and similar themes (Colorado State University, 2002). Responses were then placed into the appropriate category based on key words and themes and counted. There were a few responses that were coded into two categories, this was especially true for responses to the completely open-ended question which tended to be longer.

IMPORTANT FINDINGS

Demographics. Of the 320 social workers participating in the study, 62.8 % (n = 201) were female, 36.8% (n =117) were male and 2 participants failed to indicate their gender. The majority of the participants (91.6%, n =293) identified themselves as Caucasian or White. In addition, 2.2% (n = 7) identified themselves as African-American or Black, 1.6 % (n = 5) as Asian, 1.3% (n = 4) Latino/Latina and 1.9% (n = 6) identified as bi-ethnic. Five participants declined to identify their ethnicity. Participants brought many years of practice experience to this study with a mean number of years past their MSW degree of 25 years. In addition to their lengthy practice experience, most of the participants appeared to have quite a bit of life experience as the average age reported was 56. Participants ranged in age from 30 years old to 80 years old and 12 (3.8%) respondents declined to reveal their age at all.

Involuntary treatment experience. The majority of respondents had worked with involuntary clients at some point in their careers, with only 10.3% (n = 33) participants responding that they had never worked in this area. Over half of participants (52.8%, n =169) reported working with involuntary clients "a little," while, 36.6% (n = 117) had worked "a lot" with these types of clients. Participants were then asked to endorse the areas of involuntary treatment in which they had participated. Approximately a third of participants (31.3%, n = 100) had provided services to clients mandated to take medication, 52.2%(n = 167) had worked with clients who were involuntarily hospitalized. Thirty-five percent (n = 112) of participants had provided involuntary substance abuse services, while the most participants (62.8%, n = 201) had provided mandated outpatient counseling.

Opinions on involuntary treatment. None of the participants totally disagreed with the idea of involuntary treatment, though 14.1% (n = 45) either disagreed or were unsure. Interestingly, the vast majority of participants, 82.9% (n = 265), either agreed or totally agreed with involuntary services for people with mental illness. There was little variation between the former question about involuntary treatment in *theory* and the next question about the *reality* of implementing involuntary treatment. Most participants 74.4% (n = 238) either agreed or totally agreed with the *actual* implementation of involuntary services, with 1.3% (n = 4) of participants totally disagreeing and 18.8% (n = 60) either feeling unsure or disagreeing.

Involuntary Treatment Tasks: Comfort. Tables 1 and 2 summarize participant responses about the frequency of their involvement and their comfort level with particular involuntary interventions. It should be noted here that participants who indicated they had never worked with involuntary clients did not, as a rule, fill out the comfort/frequency sections. There were, therefore, for each of these fourteen questions, between 17 to 70 participants who declined to answer. The N at the bottom of the tables refers to the total number of participants responding in that category, across interventions. Study respondents indicated the greatest amount of comfort with emergency inpatient hospitalizations (33.8%, n = 108) with the next most comfortable intervention being the actual provision of services to involuntarily hospitalized consumers (28.8%, n = 92). The two interventions most uncomfortable to participants were seeking or facilitating an involuntary medication order as well as testifying for commitment at a hearing (13.8%, n = 44), with the provision of involuntary substance abuse services coming in as next most uncomfortable (11.9%, n = 38). A total involuntary treatment comfort score was computed for each participant by totaling their seven responses, with a possible 35 points indicating total comfort with each of the seven interventions. These scores ranged from 2-35, with a mean score of 19.42 (SD = 8.80). Approximately 75% of respondents had a score of 20 or higher. It is important to again remember that some participants seemed to only endorse the interventions they had direct experience with and 6.6% (n = 21) of participants did not provide any data at all. With this in mind, though, it is still possible to interpret these results as indicating that the majority of participants are more comfortable than not with involuntary interventions in general, especially those that relate to involuntary hospitalization and outpatient counseling.

Table 1. Frequency of Involuntary Treatment Tasks

	Never		*Frequently*	*Very Frequently*	
Variable	1	2	3	4	5
Involuntary med	58.8%	24.1%	5%	3.1%	1.3%
Emergency hosp	19.7%	50.3%	12.2%	6.9%	5%
Outpt commitment	45%	25.9%	10.9%	5.9%	2.5%
Testifying	60%	22.2%	6.9%	1.9%	1.9%
Inpatient services	43.8%	20.6%	8.4%	5.6%	13.4%
Substance services	48.1%	22.2%	9.4%	6.9%	3.4%
Outpatient services	26.9%	35.6%	16.9%	10%	5%
N = (all tasks)	967	643	223	129	104

Table 2. Comfort Level with Involuntary Treatment Tasks

	Totally Uncomfortable		*Comfortable*	*Totally Comfortable*	
Variable	1	2	3	4	5
Involuntary med	13.8%	19.4%	18.1%	17.2%	13.1%
Emergency hosp	3.4%	8.1%	18.8%	24.7%	33.8%
Outpatient commit.	7.5%	5.3%	19.4%	17.8%	20%
Testifying	13.8%	17.8%	20%	13.1%	15%
Inpatient services	5.9%	8.1%	17.5%	16.9%	28.8%
Substance services	11.9%	17.2%	20.6%	15.6%	11.9%
Outpatient services	4.7%	10.6%	23.1%	25.6%	23.4%
N = (all tasks)	195	309	440	419	467

Involuntary Treatment Tasks: Frequency. When examining the participants' responses regarding the frequency of specific involuntary interventions in their professional life, it becomes apparent that the majority of this sample of social workers does not encounter involuntary treatment with great frequency. This sheds a different light on the data regarding comfort as it would seem that many participants may have answered these questions with regard to how comfortable they *would* be in providing these services instead of from actual experience. Accordingly, the most highly endorsed involuntary intervention, providing inpatient psychiatric services, was very frequently experienced by 13.4% (n = 43) of participants. The next most frequently experienced interventions were facilitating involuntary emergency hospitalizations and providing mandated outpatient services, both endorsed at "very frequently" by 5% of participants (n = 16). By contrast, each involuntary intervention had *never* been

experienced by a range of 19.7% (n = 63) participants for emergency hospitalization to 60% (n = 192) participants for testifying at a commitment proceeding. Hence, the involuntary frequency total score that was computed by summing these seven questions had a range of 2-31, with an average score of only 12.33 (SD = 5.53). Approximately 75% of respondents had a score of 15 or below.

Involuntary Treatment: Change Over Time. After rating their level of comfort with and the frequency of specific involuntary interventions in their clinical practice, participants were asked to rate any change in their comfort with involuntary treatment over the course of their career. Choices ranged from "much less comfortable" to "much more comfortable." Thirty-five percent of participants (n = 112) indicated there had been no change, while 17.2% (n = 55) participants were much more comfortable and 24.1% (n = 77) were more comfortable. Only 2.8% (n = 9) of participants were much less comfortable and 7.5% (n = 24) described themselves as less comfortable. In sum, 41.3% of participants were more or much more comfortable, 35% had not experienced a change, and only 10.3% were much less or less comfortable with involuntary treatment since beginning their careers.

Participants were next asked to write a few words about how they felt their attitudes about involuntary treatment had changed, over time, if they had. A total of 183 (57.2%) participants wrote in answers for this question. Keeping in mind that the majority of participants were *more* comfortable with involuntary treatment over time, as indicated by quantitative data results cited above, three major themes emerged from responses to the open-ended questions. The first, and most pervasive, theme dealt with professional *experience or personal growth* over time. A secondary theme concerned *changes in job or clients* served. A final theme dealt with participants' attitudes changing because of their exposure to the *reality or impact of mental illness*. A sample of responses with their respective coding categories is displayed in Table 3.

Table 3. Major Themes of Attitude Change Over Time with Qualitative Responses

1.	**Professional Experience or Personal Growth**
	Example Quotes:
	Increased experience and comfort with role
	I'm more comfortable dealing with resistance
	More experience/seeing positive change
	More exposure and practice
	Comfort level has increased with practice and supervision
	Obtaining a dose of reality
	Greater experience in the profession
	Skill and knowledge base have improved
	Experience builds confidence
2.	**Changes in Job or Clients Served**
	Example Quotes:
	I'm just in a place I can choose NOT to do it
	I no longer work with these type of clients

I'm in a private setting with little back-up
Administrator since 1990

3. **Exposure to Reality or Impact of Mental Illness**
Example Quotes:
The patient benefits from it
Seriousness of the issues
Patients are sicker
Clients have more potential for violence
Seeing the number of homeless mentally ill patients today breaks my heart
Worked with clients so unreachable

It should be mentioned that while the majority of responses clearly fell into one of the three categories, five multi-faceted responses were coded into double categories. Additionally, 14% (n = 26) of responses could not be categorized, typically stating "little experience or no opportunity for involuntary intervention" (.05%, n = 9) or dealing with specialized situations in states, or agencies or comments regarding law changes. From the open-ended data coding it became apparent that the number one reason participants cited for their change in comfort with involuntary treatment was experience, both professional and personal. Ninety-seven responses fell into this category, accounting for 53% of responses. The second category of job or client change contained 17.48% (n = 32), of responses. The third category, change caused by increased understanding of the reality of mental illness, accounted for 16.39% (n =30) of responses.

Open-Ended Question. A second open-ended question was included at the end of the questionnaire section on involuntary treatment asking participants to record "anything else about involuntary treatment" that they might like to say. These data were analyzed in the same way as the previous open-ended question. The emerging themes were labeled and responses were then enumerated based on these coding categories. A total of 181 (56.6%) participants wrote in responses. The first, most obvious category included participant responses that spoke to the critical situations that precipitate involuntary treatment. This first category was named "Protection from Dangerousness" and contained the largest percentage of responses at 35.91% (n = 65). Typical responses included words such as "danger to self and others," "gravely disabled", "ill," and "safety" and seemed to capture the concern that people who are in crisis situation need to be protected by treatment whether it is in accordance with their wishes or not. A second category that emerged as distinct from this one included statements about how "necessary," "essential" and "warranted" involuntary treatment is. This second category was named "Necessary Treatment" and contained about 25% of responses (n = 47). These responses largely expressed agreement with involuntary treatment for people who *need* treatment and were typically less qualified by the "dangerousness" standard. The following is an example of this type of response:

> I think if those who disagree with involuntary medication/hospitalization actually work/live in clients' lives or families for a few hours [they] would agree meds do change improve their [patients/

> clients] lives. I can't understand an attorney or any idiot looking in clients'/patients' tormented eyes and fight against hospitalization/meds. At that moment the torment is too great for the patient/client to make a rational decision.

A third category included complaints regarding the system supports around involuntary treatment as well as suggestions for improving the system. This third category was labeled "Service System Problems" and contained 22.10% (n = 40) of responses. These responses varied in specific recommendations but several included concerns with the short-term, crisis-stabilization nature of treatment today: "inpatient care so brief and cursory," and, "conditions haven't been conducive to healing."

Finally, a subset of responses were clearly opposed to involuntary treatment, either inpatient or outpatient and were concerned with the issues of justice involved. This final category was named "Opposed to Forced Treatment" and contained 20.44% (n = 37) of responses. Responses here indicated the feelings of conflict that some participants believed involuntary treatment presented to other values they held, such as self-determination.

DISCUSSION AND RECOMMENDATIONS FOR FUTURE INQUIRY

One of the main contributions of the current study is the subject matter. As Dennis and Monahan (1996) point out, involuntary treatment has been with us in one form or another for centuries and it shows no signs of going anywhere. It is therefore, essential that social workers have a body of empirical knowledge to inform practitioner and agency response. Also, in this way, the debate in the literature about involuntary treatment takes on a more practical form, moving out of theoretical taking of positions and into an inventory of actual intervention issues. Hopefully this will lead to the refinement of involuntary treatment interventions and the addition of creative alternatives that may be less problematic ethically such as advanced treatment directives (Rosenson & Kasten, 1991).

One interesting result of the current research was the finding of participants' overwhelming support of involuntary treatment. Respondents generally reported that they had become *more* comfortable with involuntary treatment over the years and largely attributed the change to their increased practice experience and maturity. Also associated with increased comfort was their exposure to the reality and severity of untreated mental illness and the strengthening of attitudes about the injustice of allowing someone to "languish in their illness." Study participants also underlined the necessity of involuntary treatment, particularly in life and death situations, cited some system problems associated with its implementation as well as wisdom about dealing with its repercussions in practice. Many of the social workers who indicated high levels of comfort and agreement with involuntary treatment interventions had little actual experience with these interventions, prompting the question (for future inquiry) of what would happen to their attitudes were they to consistently deal with these issues.

The findings about involuntary treatment are important because they speak to the changing face of social work intervention in an era when outpatient commitment laws,

including mandated medication and case management services are being urged as a solution to untreated consumers (Torrey & Zdanowicz, 1999). New social workers entering mental health systems for people with mental illness need to be equipped to deal with the special challenges inherent in involuntary interventions. Frustrating system problems cited by some participants when dealing with involuntary consumers point to a need for mental health policy and practice setting changes.

Future inquiries into involuntary treatment attitudes should delineate the different types of involuntary treatment interventions prevalent in mental health treatment today. Lack of specification of involuntary interventions was evident in the fact that most of the participants in the current study indicated that they were thinking of emergency life and death situations and/or mandated outpatient counseling when responding to questions about agreement and comfort with involuntary treatment. In other words, attitudes about "treatment-need" interventions (for example, medication for a non-dangerous but ill consumer) were not extensively captured. This could account for the surprisingly high level of approval for involuntary treatment. Specifically, outpatient commitments such as those described in New York's Kendra's Law (Moran, 2000), involuntary medication and electro-convulsive treatments are all areas of involuntary intervention that should be separated in future attempts to capture attitudes about specific involuntary treatments in mental health practice.

A limitation of the current study is the sampling frame. The *Clinical Register*, while enabling the researcher to capture seasoned social workers, does not necessarily include those social workers "in the trenches" in mental health service delivery with reluctant consumers due to the high proportion of listees who are in private practice. A future study should focus on capturing this group in order to move the discussion of involuntary treatment in the social work practice literature more firmly into "real-life issues" versus ideological debate.

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