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Editorial: Let's Start at the Beginning

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Robert McKinney, Soon to be Editor

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I consider myself to be eloquent; but then, most people who write anything tend to think of themselves that way. Many of us are incorrect in our self-assessments, too. As I sat down to write this editorial, I found that I had lost my tongue. How does a person assume oversight of something that is as important to any discipline as the IJSWVE is to social work? What words might instill faith and confidence in the journal's readers, editors, and contributors? Shall I start by quoting lines from some long-dead poet who writes about change, about the march of time, about metamorphosis?

Perhaps I should start with gratitude.

To each of the members of our three boards – the policy advisory board, the board of copy editors, and the manuscript review board – thank you for accepting me as I don the mantle of editor. Serving as the editor of a journal or a book is an odd task. The editor is the person whose name is listed first. The editor is the person who, for lack of a better term, gets the credit; however, the work of the editor is largely not what matters to the readers. What matters to the readers is the content, which is largely driven and filtered by the editorial team, not the editor. A good editor will rely upon the team, while largely staying out of the way and allowing the members of the team to do what they've been asked to do. To each of you, I am grateful.

To Pascal Rudin and the International Federation of Social Workers, thank you for assuming the daunting responsibility of publishing the IJSWVE. As Steve described in a recent editorial, the journal has grown tremendously in its lifetime. As a result of this, it has bounced around from one publication home to another to another. Publishing an academic journal is not exactly what anyone would describe as a lucrative enterprise. Rather, it is a labor of love, a task that organizations undertake to advocate for their cause, to have a voice. To you and to the IFSW, I offer my thanks for undertaking such a herculean endeavor.

To Steve Marson, thank you for your faith in me. When you approached me, one of your copy editors, about serving as the co-editor of the Routledge Handbook of Social Work Ethics and Values in 2017, I was surprised, to say the least! It was a tremendous learning experience for me and one for which I will be eternally grateful to you. Now, seven years later, we're at another milestone. During your tenure at the journal, you have shepherded it through myriad publishers, with countless members of the editorial staff, and through a seeming unending array of social issues. Female genital cutting, genetic testing, electroconvulsive therapies, fatherhood, social work education, racism, far right radicalism, and refugee work are just a few of the topics that a cursory review of the journal's tables of contents reveal. To give voice to such a breadth of topics with authenticity is a remarkable accomplishment. Yours is the standard to which I obtain. I remain forever in your debt.

I came to social work late in life, and even then, it was only accidental. For much of my life, I was a working musician, playing music in bars and clubs and enjoying life. I knew that there was no real future in that life, at least not for me, but I never knew what else to do. As fate would have it, during my career as a musician, I had come to know several people who were social workers, social work educators, or social work students. All of them said some version of the same thing to me, and countless times. "Bob, you think like a social worker. You act like a social worker. You talk like a social worker. You should be a social worker!" I had absolutely no idea what they meant. When I was 40 years old, and on the heels of some significant life

changes, I heard those voices resonating in my head and decided to pursue the MSW. At the time that I entered the program, I didn't even really know what a social worker was. I only knew of two things that social workers did – school social worker and therapist. My white, middle-class, married parents background had sheltered me from so many of the realities of daily life for lots of folks; however, when I arrived at the orientation for my MSW program and the program director, Dr. Debra Nelson-Gardell, started talking about the values and the ethics of the profession of social work, I immediately knew what my friends meant when they said that I should be a social worker. I found the home that I had been looking for throughout my entire adult life.

Here in the United States, many social workers ascribe to the Code of Ethics of the National Association of Social Workers. In the first sentence of the document, the Code says that social workers pay "particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty." (https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English, n.d.). The IFSW's global definition of social work adds, "In solidarity with those who are disadvantaged, the profession strives to alleviate poverty, liberate the vulnerable and oppressed, and promote social inclusion and social cohesion." (https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/, n.d.). Unlike any other discipline, social work is a values-driven field.

There may be many reasons why people choose their life's vocations. People may become veterinarians because they love animals, or maybe because they love farming and livestock. People may become architects because they love the grandeur of beautiful buildings. People may become teachers because teachers were important to them growing up or because they really believe that they have the drive to guide future generations. People who pursue the professional practice of social work, though, are somehow different. We know at the outset that we are committing to working with and on behalf of the "others," the people about whom the rest of the world tends to forget. The world marginalizes people living with AIDS, but social workers fight for them. Armies commit injustices to entire societies

while much of the world turns a blind eye, but social workers run to the scene. We as social workers have made the decision that we will be the ones who show up, sometimes at personal risk, when others turn a blind eye.

As I write this, the world is in turmoil. There is war in Gaza. There is war in Ukraine. Myanmar. Sudan. Columbia. Ethiopia. Somalia. Nigeria. Radical right-wing extremism is on the rise in the United States. Germany. Italy. Switzerland. Even Sweden.

At the heart of the resistance to a world of injustices are social workers. We constitute an army of often unseen people who believe that everyone should get a fair chance. We believe that people don't have to be defined by their differences, by the mistakes in their pasts, or by the happenstance factors of their birth or family. As Dr. Mike Parker, retired faculty member at The University of Alabama School of Social Work says, social workers are the one who offer people who are in the midst of utter chaos a cool cup of water. We promise to listen – without judgment – and to offer the gifts and talents that we have to help people find peace, resolution, and justice.

I consider it an honor to enter the position of editor of the IJSWVE. My hope for the journal is that it will continue to grow in terms of readership, the internationality of its authors and editors, and across the scope of human existence.

Commentary from Russia/Ukraine: Part 3

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Anonymous

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Editor's Note: Following is part three of an anonymous commentary written by a friend of our journal. Part one can be found at https://doi.org/10.55521/10-020-102 while part 2 can be found at https://doi.org/10.55521/10-020-202. Anonymity is required as a safeguard for this person. Because of the political situation, it is not safe to include any names or gender identification. The author is a professor of human services in Russia but is Ukrainian. The person's family lives in Kiev and it is an emotionally troubling time for all of them. This letter has not been copy edited and is a translation from Russian by the use of Google translator.

Circles of Hell

February 24, 2022 – present day

- Bogdan, what's going on with you? They don't tell us anything. But we understand that something is wrong.

- They are killing us.

- What? Who???

- Russian troops are bombing Kyiv, there is a massacre in Bucha.

- Impossible to believe!!! How to find out and be in the know? Is everything okay with you and your family? How are Angelina, Aunt Tanya, and your relatives?

- Everyone is still alive, but under fire. I am in the defense industry, there is a shortage of medicines in hospitals and on the front lines. I'll send you a few links to telegram channels, follow the links, subscribe. These are our Kyiv channels, they contain fresh and objective news.

- Write, at any time, even at night, I'm always in touch.

- I will create a telegram chat, it will be a private, secure connection. We'll communicate there.

Sometime after this dialogue, my Facebook page, from which I corresponded with my brother, who was under fire in the city of Kyiv, was banned. To unlock it, you had to provide your passport information and take a photo against the background of the blocked page. As you understand, I refused to do this.

In a telegram chat, Angelina wrote to me:

- They are coming to us.

- Who?

- Russian troops. We call them "orcs"

-Can't you leave?

- No, this is our land, we must protect it. Our relatives, children, homes are here. My men serve in the Armed Forces of Ukraine, Bogdan serves in the defense forces. My mother is already elderly, she can't stand the move and doesn't want to leave Kyiv, and my husband's mother is bedridden, she just had heart surgery, she can't move. We won't be able to leave them and go away.

- How will you live? How to defend yourself?

- We have a cocktail bar on the edge of the village[1].

For a moment, after reading this, I thought that everything was fine with them, imagining an evening bar and people who meet after work for a glass of alcohol and calm music. But very soon I realized what kind of "bar" we were talking about.

[1] One of the villages near Kiev, for security reasons I will not list its name

- Each resident of the village has two "gun barrels" and three boxes of cartridges[2]. And in our bar they pour a chic "Bander smoothie (smooth-drink)" - Molotov cocktails. Let them come, we will meet them!

I was plunged into absolute horror again!

- Should I just give up? – not finding anything else in my head, I wrote nonsense, using at least some version of protection from imminent death.

- No, either they will leave, or they will have to kill us all. We will not give up! When their tank column was passing through our village, the priest of our church came out to talk to them. They simply shot him and calmly moved on. We have nothing to talk about with them and we will not give up!

Here I realized that this might be the last time I would communicate with them. My throat tightened, tears blurred my eyes, I remembered their faces, imagined the horror they faced. Kill a harmless, unarmed priest who came out just to talk? WHAT?.. What's going on? Who are these animals? Is this my country's army? Is this really true??? Thoughts pressed on my temples, rushing through my head at incredible speed. I imagined myself in the basement, with a machine gun in my hands. Nearby are elderly people and children who have nothing to eat and drink, nowhere to go to the toilet, nowhere to wash. Two boxes of ammunition and the brutally murdered priest of my church, whom I had known for many years, to whom I came for good advice and help... Yes, I will shoot until the last bullet. And when I run out of cartridges, I will start cutting them with knives and tearing them with my teeth when they grab me. And I will only calm down when they tear out my hands and tear off my head. I understood them and never again during these two years that this war has been going on, have I suggested such nonsense: "surrender"! I wrote that I understood them and wished them victory over their enemies or death with weapons in their hands, I wrote that in fact there is no death, because there will be a resurrection of the dead, which is written about in the Bible.

---

[2] Firearms (colloquial slang)

It was a moment, but when I came to my senses, it turned out that about half an hour had passed. I was supposed to take an academic course; I studied at Moscow University. I realized that I was late to connect to Google meet. I needed advice. It is impossible to explain my psychological state in which I was. I was shaking, my palms were sweaty, and it was difficult to breathe. The temples were being squeezed as if in a vice. I felt that I was close to some kind of attack, I urgently needed to find a way out!

I entered Google-meet. Fortunately, the couple was led by a psychiatrist, Doctor of Medical Sciences. We could not help but discuss the alarming situation, which, moreover, obligated us to transfer face-to-face learning to distance learning. Being a high-class specialist, the doctor asked: "Which of us present at the couple is currently experiencing an anxious state in connection with the events taking place?"

I answered:

- I have.

She asked to describe the situation. I told it like it is, I was never afraid to tell the truth. A little later you will understand why.

After carefully listening to my entire story about relatives in the Kyiv region, and about the fact that they will resist and will not surrender, and about weapons, and about Molotov cocktails in their local "bar", and about how a column of Russian occupiers passed through their village, and about how the Russian military shot and killed a local priest.

At the same time, about 30 people were present at the academic couple; they immediately learned the truth about what was happening in Ukraine. The doctor asked the same question as me:

- Don't they want to give up?

"No," I answered. – And I understand why.

- I understand too, but still, this would be a more reasonable decision. But you and I are not there, so we can only talk about it, and of course they make the decision. What can we do in this situation? How can I help them? Now I'm not talking about the entire village, but only about your family. – She asked with genuine sympathy.

And then I remembered: indeed, Angelina wrote to me about her granddaughter, who needed the help of a psychiatrist, since after the explosions the girl had symptoms of post-traumatic disorder with fixation of the reflex arc. When the explosions stopped and she was already safe, the slightest knock or unexpected sound like a blow or bang (for example, when doors are closed) would cause her to have a panic attack and vomit. Because of this, the child could not live normally: sleep, eat, do homework, read, communicate, etc. I told our psychiatrist teacher about this. She immediately suggested a treatment plan:

- Do you remember what desensitization is? Let them do the following: when the girl is not waiting, they make claps (for example, soft knocks on the door), to which she will react. And gradually let this sound move away from her. When it is possible to establish a distance at which the child will no longer react to sounds, let them repeat these sounds at the same distance at different times of the day and night, but only let them carefully monitor that there is no reaction of the reflex arc. And then, after 5-7 days, let them begin to reduce this distance. But this needs to be done gradually. There is no way to do this without drug treatment, so let them get the drug Atarax. Let them read the instructions carefully about what doses a child of this age should take[3]. And let them contact a psychiatrist as quickly as possible, if possible.

I thanked her for her help and participation, it became much easier for me - a mission to save a child appeared, and from this my problems and the problems of all adults faded into the background. I waited impatiently for

[3] Attention! This prescription from this psychiatrist is not a guide to your treatment, since it was given on an individual basis in a specific situation for a specific child with certain symptoms. It is real, it can be kept in mind, but before you apply this treatment regimen, seek the advice of a practicing specialist: a psychiatrist or a medical psychologist and describe YOUR situation and symptoms of the disease. The use of a particular treatment regimen depends not only on your age/symptoms/body weight and associated comorbid disorders, but also on the etiology of the disease, i.e. depending on how you received it.

the end of the academic couple and wrote about everything that the psychiatrist said to Angelina. They applied the treatment and it helped. Soon this girl, together with her mother, the wife of Angelina's son, moved from Ukraine to the USA, now they live quietly in North Carolina. And thanks to the kind person who provided them with his home to live in.

When all the problems with Angelina's family faded into the background, I returned to the situation at the front. We were together again: we sent each other photos, videos, shared our impressions of this spring, supported each other.

These days of communication flew by unnoticed, at first I could not focus on the problems that they had, this required complete immersion, and I was actively studying at the university and often participated in scientific conferences. But at the same time, I started watching news from telegram channels in the city of Kyiv every day.

And then the nightmare began!!!

I remember it in some fragments - psychological defense and repression are triggered. Be patient, dear readers, understand that it is still difficult for me to describe it. Memories come, but also in fragments.

I remember how I was going to the university in Moscow, getting on the metro, waiting for the train, and when it approached, stepping over the threshold and moving towards the handrail near the door opposite the exit, I fell through time and space, transported in my mind to where I saw the girls on the news who spent the night in the same metro train, only in Kyiv, right on the floor. They spread blankets there, put pillows, toys, their school bags and backpacks, did their homework there, ate some food and told how they had been living there for several days, because Kyiv and the region were being bombed. I looked at this place on a Moscow metro train and couldn't understand: HOW??? How is this possible? To sleep here, right on the hard, cold floor, in the cold, half-starved, half-naked in front of everyone?.. I woke up a few minutes later, I wanted to look into the eyes of the people sitting and standing around me to understand: do they FEEL THIS? Or is this just my reaction to what I saw in the Kyiv news? And you know, I SAW the same reaction. Not for everyone, but for many. Do you know what

it looked like? People looked straight ahead at one point. The look was at the same time empty, emotionless and, at the same time, somehow doomed. And this is the reaction I was looking for. It was remorse, regret, sympathy, disappointment. And I calmed down a little: because next to me, everywhere every day, I saw people who silently asked for forgiveness from God and the Ukrainians for what their government and army were doing. If these people had not been there, I don't know how I would have managed to control myself. I probably would have committed some kind of criminal offense and would already be in a Russian prison.

Once, when I was traveling on the subway, I saw a man - a tall, slender, handsome middle-aged man with gray hair, who was crying right on the train. This was my first experience when I saw a man crying like that, in a public place. My heart sank, I still think: how could I help? Maybe I should have spoken to them?.. But I didn't dare.

Then there was a boy, I think, from Mariupol, who lost his mother during the bombing, she died. And due to the fact that it was impossible to bury the dead in cemeteries, they were buried right on children's playgrounds and houses. Often in sandboxes, where just a few months ago children were happily playing their games. Now his mother was buried in such a sandbox. He came to his mother's grave, to this playground, where a few months ago he had walked and played with her, and now he was picking wildflowers somewhere and bringing them to her grave. People gave him food: cans of condensed milk, cookies, bread - whoever had what. But you know, one day they noticed that he took everything that he was given to eat to his mother and put it on the hillock of this sandbox. When asked: "What are you doing?" He answered: "This is for mom; she also wants to eat." And people, realizing that the boy treated his mother as if she were still alive, and that it would not be possible to convince him otherwise, began to give him two portions of food so that he could leave one at the grave for his mother, and the second he could eat. It was simply unbearable. I still cry when I write about this.

Then there was a man who, during the evacuation from Irpen[4], lost his family: his wife and two children. They were killed by one bomb, they walked together, and he walked away from them for a few minutes to find out which bus to leave with. At that time, the mother and children stood at a distance with their things. An explosion thundered, the man turned around, and they were already torn to pieces. He was interviewed a short time after this event. It is impossible to express in words how this man felt. As a future specialist, I saw what kind of emotional and psychological state he had - he would never again fill this void in his soul. Everything that was good, beautiful and creative was stolen from her. What's left? You understand yourself. And it's scary.

After that, Angelina sent me a video where they pulled out a small dead child from under the rubble of a bombed-out residential building. It was so strange to see how they cleared away the rubble and after a few seconds they pulled out an absolutely pale, lifeless little body, limp and very white. They pass it from hand to hand, the women scream, there is silent hatred on the faces of the men, and endless rage in their eyes. The death of a child is always something special, because not only a new life has ended, but the very hope for the future, its prospect, has died. And this always has a very strong impact on the psyche of those who survived. They will never be the same again.

Every time I get my nails done, I think of that girl whose body photo was spread all over the world. Remember this photo? Yes, you remember it, I have no doubt: a manicured hand, lifeless, stained with blood and dirt, next to the bicycle. I remember a video shot from a drone using video recording: here she is, still alive, going out to her home street on business on

[4] One of the cities in the Kyiv region that was attacked by Russian troops. The site of war crimes by the Russian military. In this city, after its liberation from Russian invaders, mass graves were discovered containing bodies of people of all ages and genders, with their hands tied behind their backs. They were shot point-blank, many of them were brutally tortured before death.

a bicycle. It is possible that someone was waiting for her at home or she went to work, or to buy groceries at the store, or somewhere else, as each of us does every day. Here she turns the corner to continue her journey. And then a tank comes out from around the corner of a nearby street and fires a salvo from its gun...

Thoughts flash one after another: "Creatures! Who are you shooting at??? These are civilians!!!"; "This is right near Kiev, Angelina, Bogdan and their whole family are there!!!"; "How to enroll in the Armed Forces of Ukraine? I want to kill these freaks, I just can't do it anymore, they all need to be destroyed, such animals have no place in the sun!!!" I start to pray. And suddenly I receive clear guidance. Instead of aggression and the desire to destroy everything around, wise, good thoughts come, they become organized, and I already know what to do.

Then there was a lot more that you could write a whole book about: there was the Drama Theater in Mariupol, there were cities and towns wiped off the face of the Earth, which the Russian military for some reason called "strategic military targets" of some "nationalists" and much more. . But I need to focus now on the main thing: on the mechanism by which the devil and demons transform the human essence into a demonic one. And they know a lot about this, believe me. They act through the eyes: it is enough for a person to see the injustice being committed, especially if it is associated with the gravest atrocity, and the person, out of mercy (!!!), since he feels sorry for the victim, himself turns into a beast. Oooh, don't be fooled! This is their stroke of genius!!! With its help, they very quickly turn the divine creation into a beast that knows no mercy.

I really want to end this part of the story with one parable, remember it, I ask you. You will find it in your Bibles in the book of Matthew, chapter 12. Jesus Christ, explaining how this happens, told his disciples one parable: "[43]When an unclean spirit comes out of a person, it goes through dry places in search of shelter, but finds nothing. finds. [44]Then he says, "I will return to the house from which I came," and when he arrives, he sees that the house has been swept, decorated, and unoccupied. [45]Then he goes and finds seven other spirits more evil than himself. They enter that house and stay there to

live. And the person becomes even worse than he was at the beginning."[5] There is one very important idea in this parable: evil multiplies if there is no divine principle in the soul, that which God has invested in every person (conscience, faith, goodness, mercy). Demons understand that such a devastated soul is an easy prey! Have you noticed how those people, some Ukrainian military personnel and those who suffered from Russian aggression, at the beginning of the war said in all interviews and reports: "We are not like them (Russian military), we do not kill defenseless civilians." And then they supported the bombing of Donbass cities and terrorist attacks in St. Petersburg and Moscow. This is the metamorphosis of metaphysical Evil! Rebirth occurs unnoticed, it is covered with false slogans about fair retribution, although there is no justice in this. And now man, God's magnificent creation, supports, or, worse, personally participates in the murder of innocents. He begins his journey through the circles of HELL, unaware that he is already caught alive in Satan's trap[6]. You can only be freed from it by knowing the truth of the Good News. That's why I consider this work the most important. Let me explain why.

Jehovah Witnesses

August 1992 - present day

- Hello! I wanted to share with you one very wise thought from the Bible! – near my husband, when he was on his way to work on a city bus, a conversation arose between two passengers. The husband turned around. On the next seat sat two people: one in a classic suit and tie, the other in a tracksuit and cap. The man in the tie, a charming young tall blond with blue eyes, continued:

[5] Bible, Gospel of Matthew, chapter 12, verses 43 to 45
[6] Bible, 2 Timothy chapter 2, verses 25, 26

- Look at what is written in the book of Matthew, in the 24th chapter: "6 You will also hear about wars and rumors of wars. See that you are not horrified, for all this must come to pass, but it is not yet the end: 7 for nation will rise against nation, and kingdom against kingdom; and there will be famines, pestilences and earthquakes in places; 8 after all, this is the beginning of illness. 9 Then they will hand you over to torture and kill you; and you will be hated by all nations because of my name; 10 and then many will be offended, and will betray each other, and will hate each other; 11 and many false prophets will arise and deceive many; 12 and, due to the increase of iniquity, the love of many will grow cold; "He who endures to the end will be saved." And further, verse 14: "14 and this gospel of the kingdom will be preached in all the world as a testimony to all nations; and then the end will come." – everyone on the bus became quiet for a minute, listening to the verses from the Bible[7].

The preacher, smiling and not at all embarrassed by the ensuing silence, continued:

-Have you paid attention to what Jesus Christ said to his disciples in response to their question: "When will this system of things end?" He said that before such difficult times come, the Gospel must first be preached. This is what I do. If you want, I can come to you at any time convenient for you and study with you... - he did not have time to finish his sentence, he was interrupted by a man in a tracksuit, to whom the preacher was addressing.

- Fuck you with your Bible! – he suddenly shouted unexpectedly sharply and completely without reason. "If we weren't sitting on the bus, I would put this Bible on your head right now!" Sectarian! – the man rose sharply from his seat and began to move towards the door of the bus, preparing to get off at the stop.

The young preacher was not at a loss and answered in a calm voice:

[7] Bible, Gospel of Matthew, chapter 24, verses 6 to 14

- Don't worry so much, I won't bother you anymore. "He looked around, met my husband's eyes and said, smiling and shrugging his shoulders. - Doesn't want to listen...

My husband immediately replied:

- And I want! Can you tell me what will happen after the Gospel is preached throughout the earth?

The preacher, smiling, handed my husband a Watchtower magazine and said:

- I'm getting off the bus now, it's already my stop, I'm going to work. But we can still meet. We now have very few such publications; they come to Russia from abroad. We gather on Sunday mornings at 10 o'clock at the local Palace of Culture. Will you come? There will be a very interesting spiritual program there. If you have a spiritual interest, you will enjoy it.

My husband replied:

- Yes, I will definitely come.

The next day, I was returning home from a short trip, and my husband told me about how he met a Jehovah's Witness on the bus, and how he invited him to a meeting on Sunday at the rented Palace of Culture. Without hesitation, I agreed to go, since I had long been interested in spiritual issues that were raised by my school biology teacher and my grandmother. They were opponents, I wrote briefly about this in a previous article, and I really wanted to know: which of them was right, the biology teacher who firmly believes in the theory of Charles Darwin, or my grandmother who tells me about the miracles of Creation. In addition, I directly encountered some circumstances in my life that clearly hinted at the presence of spiritual forces. I'll tell you a little about this, since the entire further narrative will not carry any real emotional and psychological load without explaining my feelings and attitude towards God as a really existing person.

So, from the event described above, we now have to move back a few years ago, to the moment when my husband and I met in the same military unit, when we were doing compulsory military service. I will not go into detail, since I described some of the circumstances associated with serving at the headquarters of the strategic air force of the USSR in a previous article.

So, at that time I was a radio operator in the Air Force. Our duty lasted 12 hours with breaks on weekends. And in the evenings, when it was quiet in the closed, isolated and guarded radio room, I loved to read books. And then one day I came across Mikhail Bulgakov's brilliant novel "The Master and Margarita". There was a main character who amazed me with his spiritual and moral strength. If you open this novel and start reading it, pay attention to such a character in the story as Yeshua Ha-Nozri. And try to understand how a person who had never held a Bible in his hands could feel[8].

If you open chapter 2 of the novel, which is called "Pontius Pilate," and read it, perhaps you, like me, will be amazed by one very curious phenomenon. This chapter describes a completely unusual, amazing person who values human life and each person as an individual so much that even after cruelty was shown to him, he calls such people "Kind Man." When I imagined myself in his place, I involuntarily realized that I would have behaved completely differently, and at the end of the novel, having learned even more about him, I finally realized that responding with good to evil is an unprecedented example of courage, honor, high dignity and morality!!! And I also realized that this was some completely different person, that all people on Earth were not like him (which made my heart very sad), and that he, as Bulgakov's wrote, was the Son of God! When he was executed on the stake, and Levi Matthew, his disciple, tried to stab him to death before execution in order to save his Teacher from torment, and he failed, I scolded him so much that my heart hurt. In the dream, I imagined that I was running with a knife in my hand and trying to penetrate the dense ranks of the Roman

[8] Such ignorance for young people in the USSR was an absolute norm, since for carrying, reading and storing the Bible or its individual books in the USSR they could easily be imprisoned or sent to distant camps, accused of any mortal sins, or fabricated any criminal case. Such people were objectionable to a system based on a totalitarian unity of opinions. And such a person as GOD - the Lord of the Universe, could compete with the idols of communism: the party, V.I. Lenin, General Secretary of the Communist Party of the USSR (the position of the leader of the country) and so on.

legionaries who were guarding Yeshua on the way to Golgotha, and I imagined how I would plunge this knife into the very heart of Yeshua so that he would never know the torment to which he subjected. And a little later, reading the novel again, it was me, instead of Levi Matthew, in the pouring rain during a storm that broke out in Jerusalem, who ran to Golgotha in sandals on my bare feet and wet burlap to remove his body and bury it until the crows pecked out his eyes and liver! It was I who climbed the clay mountain on which stood the pillars of the executed, my nails dug into this dirt softened by the rain, I scolded God for allowing his Son to die, who first taught me that "all people are kind, no evil people in the world!!!" YES!!! YES, my Teacher, I always knew this, my believing grandmother told me about this, because evil is the devil and demons, and not man himself!!! After all, man is the crown of God's creation, and only the devil and his demons disagree with this! This novel shook me to the core. He just made me a different person.

The second moment of my spiritual rebirth, which is important to understand my further decision, is the spiritualistic practices that my childhood friend and I became interested in. This happened at the same time. We always gathered at her house and played the piano, since we both graduated from music school. But now in our evenings by candlelight, in addition to Bach and Beethoven, we began to include a spiritualistic séance. At that time, Viktor Tsoi had just died, and we constantly evoked his spirit along with others. We had fun, asked him various questions: about marriage, children that we will have in the future, about their names and appearance, and so on. At first, we considered the fact that the spirits answered us to be simply mischievous. For example, when I sat and watched the gypsy needle move in a circle, I thought that my friend was just having fun, swinging it in the direction where the word "Yes" or "No" was located[9].

[9] The spiritualistic circle of the Slavs is not a board with inscriptions, but a large hand-drawn circle, around the perimeter of which there are letters and numbers,

When I sat down at the needle, it seemed to me that everything that was happening was just a coincidence. But one evening we asked our spirit (or one of them) to write poetry for us. And imagine our surprise when, moving in a circle, the needle began to stop, against the laws of physics, on the letters that formed the words, resulting in a beautiful poem! We checked this several times, changing places with each other - everything happened again!!! We suddenly realized that our spiritualistic practices were no joke! We became scared. Even then we understood that communication with evil spirits is bad; adult women: mothers, sisters told us about this. Their warnings looked like this: "If you see spilled rice, sugar or millet near the door, don't clean it up yourself, wait for me. And under no circumstances should you step on it, step over it carefully and close the door." Sometimes, during the first snow, somewhere in October-November, on our streets you could see an expensive new snow-white downy shawl neatly spread across the sidewalk, which everyone carefully walked around without stepping on it. We knew that witches lived in our city. Spoilage was a common phenomenon in our city, and doctors in this case were not able to diagnose a disease from which in a short time a young beautiful woman, blooming and

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and on a surface divided in half, the word "Yes" is written on top, and the word "No" on the bottom. Exactly in the middle of the sheet, a dot is placed into which a "gypsy needle" is placed, which has never been sewn (it is called a gypsy needle because such a large steel needle was used to sew mainly horse saddles and other leather products, since gypsies mainly used to keep horses). A black wool thread had to be threaded into the needle. It was for her that, sitting above the spiritualistic circle, the medium held a needle, which, when the thread was slightly released, began to move in different directions, answering the questions of the medium. The ritual of summoning the spirit is accompanied by a special spell, which must be recited both before and after the session. It is believed that if you do not cast a spell after and do not say goodbye to the spirit, it remains in the house, and this can lead to unpleasant consequences for the medium and his family and friends, as well as everyone who is in the house. During the entire session, from its very beginning to its end, the windows in the room must be open so that the spirit can "leave" at any moment. The entire session is carried out with the electric light turned off, using candles.

bursting with health, could become an old woman literally in weeks and die without receiving any help from doctors.

We knew all this, and there were other reasons why my friend and I still had the intelligence and prudence to leave spiritualism. But I must say that after that the demons did not leave us for a long time, and I have been fighting them all my life. And my friend, to my great regret, did not accept the Good News and blasphemed. I continue to pray for her, before God's Judgment comes, there is hope!

Thus, by the time I arrived home from my short trip to my husband, I had long been ready to accept the Good News, and I had a lot of spiritual interests and problematic issues that I intended to resolve. So, from the first meeting with Jehovah's Witnesses, we ended up in their Kingdom Hall, and never missed a single meeting or Congress until Russia adopted a ban on their activities, violating the constitutional rights of Russian citizens to freedom of religion[10]. Our children: a son and a daughter, were also baptized as Jehovah's Witnesses. They later chose their own path, but remained believers forever, and this greatly affects their lives in a positive way, both in their studies, in work, and in relationships with others.

We were lucky enough to meet these amazing people immediately after the collapse of the USSR, when our country, stability, peace, happiness and future were taken away from us. For some time, we found ourselves in real hell. I will not repeat the fact that Russians began to be killed in all the republics of the former USSR in previous issues of the magazine. Unrest also began in Russia itself. Bandits and corrupt officials seized power. All rights were taken away from us: to free medical care, to free education (including higher education), to free housing (in the USSR everyone was provided with free comfortable apartments). Food products disappeared from store shelves, there was nothing to eat, and hunger began. Those who worked

[10] Constitution of the Russian Federation (adopted by popular vote on December 12, 1993, with amendments approved during the all-Russian vote on July 1, 2020) // Collection of Legislation of the Russian Federation of 2014, No. 31, Art. 4398, art. 28

were not paid wages, because local managers stole money, invested it in goods, and sold it. And people sat without money and waited for this product to be sold and their salaries to be returned to them. If a leader who stole the wages of his subordinates became bankrupt and lost these funds, then people were left with nothing. Sometimes money was simply stolen and hidden abroad, more often in EU countries. This is how the oligarchs appeared. Almost all the rich people from the former USSR, no matter who they are by nationality, are simply dishonest officials, businessmen, bankers and bandits who robbed their own fellow countrymen and betrayed their country. It is impossible to describe the horror of what is happening. To do this, it would be necessary to write a book in five volumes of a thousand pages, and not one paragraph in a short article. But I think that if you are not indifferent to the history of human civilization and the search for the cause of the events taking place today, you can raise historical facts about the so-called "perestroika" after the collapse of the USSR and draw your own conclusions.

Years of preaching the Good News as baptized Jehovah's Witnesses have shown me, my husband and our children that everything written in the Bible is true. We are still, even under the ban, trying to fight our demons, and we know for sure that this is not just evil in our soul - they are REAL! And those who do not understand this are in great danger!!!

Years of preaching the Good News as baptized Jehovah's Witnesses have shown me, my husband and our children that everything written in the Bible is true. We are still, even under the ban, trying to fight our demons, and we know for sure that this is not just evil in our soul - they are REAL! And those who do not understand this are in great danger!!!

In 2017, six months before the official ban, at the last openly held Congress of Jehovah's Witnesses in Moscow, Russia and the bloc of states that support it in the rapidly approaching war of God, Armageddon, were declared the "King of the North." This block of East Asian states, led by the Russian Federation, opposes the "King of the South" (Anglo-American World

Power)[11]. At the end of this confrontation, the King of the North, having gained a seeming advantage for a short time, LOSES the fight. This is how the Bible speaks about this inglorious end: "And he will plant his royal tents between the grand sea and the holy mountain of Beauty; AND HE WILL COME ALL THE WAY TO HIS END, AND THERE WILL BE NO HELPER FOR HIM."[12] This is the main idea that I would like to draw the reader's attention to.

We learned about these 5 years before the open attack of the King of the North on Ukraine. And, although this was a terrifying event, it cannot be said that it greatly surprised us: "Forewarned is forearmed," as the wise proverb says. But those feelings, thoughts, desires that overwhelmed me after that - that's what was really difficult for me to cope with. I mean my military training, my oath and my family in the city of Kyiv, which was under attack. I took the oath to the USSR - the Union of Soviet Socialist Republics, one of which was Ukraine. I took the oath to Ukraine! And as a person liable for military service, she had to be there and use her abilities to protect the innocent, defenseless civilians being killed. But at the same time, I was already a Jehovah's Witness. I had an agreement with God, and He, for his part, fulfilled it very exemplarily. We lived all this time without needing anything. Our congregation helped us, we found peace and tranquility in our souls, we had a mission that God himself entrusted to us! This is the preaching of the Good News of the Kingdom that will very soon destroy all earthly governments and rule over the Earth. There will be no more wars in this earthly Paradise, because everyone who wants to participate in them will be destroyed. The devil and demons will be imprisoned in Tartarus and will no longer be able to harm people. For a thousand years after Armageddon,

[11] The author asks you to take into account that he gives all comments and explanations of biblical prophecies based on his own understanding, and asks those who want to know the official version to turn to the original source of information

[12] Who Is "the King of North" Today?/URL: https://www.jw.org/en/library/magazines/watchtower-study-may-2020/Who-Is-the-King-of-the-North-Today/

people will come to perfection, be healed, resurrected, become young and build Paradise on Earth, which was lost due to the sin of Adam and Eve. The book of the prophet Ezekiel talks about how, after God's war "Armageddon", the people who remain alive will burn weapons - this process will last several years!!! Imagine how important this is for Jehovah God: people who have just escaped from Armageddon will first of all deal with the destruction of weapons. And no one else will ever dare, for one reason or another, to destroy the life that God himself created in the womb of a woman! This means this question is the most important for Him.

In addition, there was one more principle that did not allow me to simply leave for Ukraine without looking back and join the ranks of the Armed Forces of Ukraine - this is a passage of Scripture from the book of Isaiah, chapter 2 from verses 2 to 4, which says that the peoples who will come to worship Jehovah "They will no longer learn to fight" (book of the prophet Isaiah 2 chapter, 4 verse). Weapons will be converted into working tools for cultivating the land, growing fruits and bread, and for other peaceful purposes. And those who were baptized as Jehovah's Witnesses were obliged to follow this principle, as having entered into a covenant with God already now!

There was one more circumstance that left me no alternative - this was the mission that God entrusted to his servants. We must preach the Good News. (maybe someone imagines Jesus Christ and his apostles with machine guns in their hands, but for me personally this is completely unthinkable! And since being baptized, every Jehovah's Witness takes upon himself the responsibility to follow Christ, to be his disciple and follower - he is simply having no right to do otherwise, since by declaring himself a Christian, he is obliged to follow in the footsteps of Jesus Christ. Or he must renounce his discipleship and make his own choice. These things: weapons that kill people and the Bible are incompatible! God has already put a weapon in our hands - this is the spiritual sword, the Word of God, the Bible: "because we have a struggle, not against blood and flesh, but against the

governments, against the authorities, against the world rulers of this darkness, against the wicked spirit forces in the heavenly places.."[13]

Therefore, I ask you: when you learn about someone who, being a Jehovah's Witness, cannot take up arms, treat this with respect, such an act testifies to courage and unusually strong faith. We know in advance the outcome of the battle; we know who will win. But we also know that this world is coming to an end, and our task is not to run across battlefields with a machine gun in our hands (other people will do this for us), but to save people by preaching the Good News to them. Purify their hearts and souls, heal them spiritually, and also explain and warn about the disaster that is approaching our planet. It is very important here to have a warm heart and a cool head in order to understand that everyone is good in their OWN place.

So, the final decision has not yet been made, but I continue to fight. I decided not to remain silent, despite the consequences. I was able to tell the truth about the events taking place in Ukraine not only to my student group, but also to our teachers: professors, doctors of science, and other representatives of academic circles. I also try to use every opportunity to preach the Good News. In the conditions of the ban on Jehovah's Witnesses, I even have some advantage, since after moving to Moscow and entering the university, I have not attended meetings for a long time and am not under the "cap" of the special services. I decided to take advantage of this situation. Thus, my mission has been enriched and expanded to include the salvation of souls: I help people understand what is happening in Ukraine, so that they can remain humane in these terrifying conditions; and at the same time, I try to use every opportunity to tell them that Armageddon is coming. I am quite satisfied with this situation. And, of course, I told my dear family from the city of Kyiv about everything. Fortunately, they turned out to be deeply religious Orthodox people, and when we correspond, we have a lot to talk about on spiritual topics. The Bible not only answers many questions that are unclear to most people today, but also gives hope for the future.

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[13] Bible, Ephesians, chapter 6, verses 12

When I close my eyes, I see two girls holding hands and walking through a golden wheat field. They sing a song, their eyes are directed forward, full of hope and expectation of happiness, their wreaths, woven from chicory and daisies, adorn their heads. The sun floods the golden rye with light and at some point they disappear somewhere beyond the horizon against the background of the blue sky. But I am no longer afraid for them, because they are in PARADISE on Earth, which our God Jehovah promised us. I just know what it will be. And I just know that it's us: me and Angelina. Throughout my entire difficult and eventful life, God has never lied to me! How can I doubt that He will fulfill His promises? Don't doubt it either!

I ask you: when you meet Jehovah's Witnesses, take just 10-15 minutes to listen to them. It could save the life of you and your family in the fast-approaching war of Armageddon. And thank you for taking the time to read my life.

With gratitude, Stranger.

Letters to the Editor

DOI: 10.55521/10-021-203

Stephen M. Marson & Donna DeAngelis, Editors

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1

Elena Delavega, IJSWVE Editor

Dear Steve,
Thank you for your service and your leadership all these years!
Elena

Elena Delavega, PhD, MSW
Professor & DSW Program Director
School of Social Work

2

Ann Callahan <Ann.Callahan@eku.edu>, IJSWVE Editor

Wow, Steve. What a contribution you have made to our profession. It seems too feeble to thank you, but I do. Enjoy your well-deserved break from such a huge responsibility.
Ann

Ann M. Callahan, PhD, LCSW
Professor, Master of Social Work Program
Department of Social Work, Eastern Kentucky University

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Thank you so much Steve for all your hard work helping all of us and improving our profession.
Best wishes to Dr. Robert McKinney.

Abdulaziz Albrithen
Professor of Social Work
College of Humanities & Social Sciences
United Arab Emirates University

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Laura Gibson <laura.gibson@brescia.edu>, Book Review Editor

Steve,
It has truly been an honor and a pleasure to work with you. As the Book Review Editor, you have given me the opportunity to grow professionally as well make a contribution to the profession I love. Since we met on the ASWB exam committee, I have had tremendous respect for your expertise and experience. I appreciate and thank you for your support over the years. I also welcome Robert McKinney to his new role and look forward to working with him. Pascal could not have said it better, and I wholeheartedly agree. The success of the journal has been due to your talent, hard work, and commitment.

Warmly,
Laura Gibson

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Pascal Rudin <pascal.rudin@ifsw.org>, Publisher

Dear Steve,
Thank you for your message and for the dedication you have shown over the past 24 years as the editor of the International Journal of Social Work Values

and Ethics. Your contribution to the journal and to the field of social work has been immense, fostering a space for critical dialogue, ethical reflection, and scholarly excellence. The fresh vision you speak of is a testament to your commitment to the journal's growth and relevance in changing times.

We welcome Robert McKinney as the new editor starting with Volume 22 Issue 1. We are confident that under his leadership, the journal will continue to thrive and evolve, building on the strong foundation you have established. Your decision to assist Robert during the transition is greatly appreciated and will undoubtedly benefit the journal's continued success.

The publication timelines for Volume 21 issues 1 and 2 are noted, and we look forward to the insightful contributions these editions will bring to our readership. The announcement in Volume 21 Issue 1 will serve as an important marker of this significant transition within the journal.

On behalf of IFSW and myself, I extend our deepest gratitude for all the help and hard work you have contributed to the journal. Your efforts have not only enhanced the discourse within the field of social work but have also significantly contributed to the profession's ethical and values-based practice globally.

We wish you all the best in your future endeavors and look forward to your continued involvement in the journal as Robert McKinney takes the helm. Thank you, Steve, for everything.

Warmest regards,
Pascal Rudin
Publisher

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Michael R Daley <mdaley@tamuct.edu>

Steve:
You have made a great contribution over the years and established a very important journal. You can be very proud. I will miss working with you. Very best wishes moving forward.

Well deserved. Having been an editor of two journals, one of which I started. I know how challenging the work can be and you were very good at it. Before USVWE it was difficult to get material on social work values & ethics published. I don't think the subject was really considered real scholarship. That has complete changed thanks to your efforts. It is a significant accomplishment. But I do know there does come a time to let someone else take the lead on things with a journal. And I do wish you well with your next step.

Mike
Michael R. Daley, PhD, LMSW-AP, ACSW
Regents Professor & Chair, Department of Social Work
NASW Social Work Pioneer
Texas A & M University - Central Texas

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Sanjoy Roy <sanjoyroy30@gmail.com>

Dear Prof Stev
It was really wonderful experience to work with you. Best wishes. We will continue to work further as well.
Regards

Dr. Sanjoy Roy (MSW, LLB, M.Phil., Ph.D.)
Professor & Head

Department of Social Work
(UGC Centre of Advanced Study) &
Director, Institute of Life Long Learning (ILLL)

8

Elaine Congress <congress@fordham.edu>

Steve
Thank you for all your expert and dedicated leadership of our journal over the last 24 years! In addition to your expert knowledge about social work values and ethics, you have also modeled for us how a social worker leader should direct an organization in an inclusive, non-judgmental way. I have always admired how well you have navigated challenging professional issues in editing our journal and how much time and effort you devoted to our journal. Even though you are retiring as editor I hope you will continue to be involved.

I look forward to working with the new editor Bob McKinney as we continue to make our journal even stronger and more widely read by social work professionals and students around the world.
Elaine

Elaine Congress, MSSW, MA, DSW, LCSW
Associate Dean and Professor
Fordham University
Graduate School of Social Service

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revakh@earthlink.net

24 years, Steve. That's incredible, and your dogged devotion is incredible. Also, your vision has worked out just fine. Good for you, though, making this decision. I know it was hard.
Kathleen

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Allan Barsky <abarsky@fau.edu>

Dear Steve. I appreciate all that you've done for the journal from its inception to the current situation and transition. Your work has contributed greatly to the field of ethics, the professional of social work. All the best with your next adventures.
Allan

11

John McNutt <mcnuttjg@udel.edu>

Wow! This is the end of an era. Steve, thank you for your years of devoted effort. You build a phenomenal publication and a wonderful community to support it. In doing so, you uplifted the profession and all who serve within.
Best, John

12

Ravita T. Omabu Okafor <ravitaok@ravitaokafor.com>

WELL DONE!! I appreciate your inviting me to serve as a reviewer, and I wish you EXCELLENT health, joy, and peace for the next leg of your journey. You have been a true asset to the profession.
CHEERS TO YOU!!
Ravita

Ravita T. Omabu Okafor, MSW, LCSW, PLLC
Adult-Child Counselor/Trainer/Consultant
Chair, NASW-NC Chapter Ethics Committee (2004-March 2022)

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Felicia Parker-Rodgers <flparkerrodgers@gmail.com>

Gratitude, Steven, may you be blessed in your coming and goings!

Best wishes!
Felicia Parker-Rodgers, LCSW, BCD, DACM

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Teresa Francesca Bertotti <teresa.bertotti@unitn.it>

Dear Steve,
thank you for your leadership and dedication as editor of the journal
I am grateful for having met you and the board
Thank you, Robert, for taking the role and look forward to working together.

Best regards
Teresa Bertotti

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Diane Falk<Diane.Falk@stockton.edu>

Dear Steve,
Thank you so much for having the vision to create the journal and for doing all the hard work to sustain and nurture it for so many years. And thank you for Inviting me to be a part of this work!
Diane

Diane S. Falk, Ph.D., LCSW
Professor Emerita of Social Work
Stockton University

16

Judy Krysik <Judy.Krysik@asu.edu>

Steve,

Congratulations on your decision. I agree with John – this represents the end of an era! You have the journal in an excellent position to hand off to the new editor. So much growth over the years, so much work, and so many decisions and transitions. What a board you have grown. It has been a pleasure getting to know you and working with you. Thank you for your incredible service and contributions to social work.

I hope we keep in touch.

Regards,

Judy

17

Ogden Rogers <ogden.w.rogers@uwrf.edu>

IJSWVE Editor;IJSWVE Policy Board

Dear Steve:

Thank you for your vision, stewardship, and friendship. The IJSWVE has been served well by you. Again, thanks. Dear Bob: good luck and also thanks.

Ogden Rogers, Ph.D., LICSW, ACSW
Dean (Ret) & Professor emeritus of Social Work
University of Wisconsin-River Falls

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Céline LEMBERT <celine.lembert@anas.fr>

Bonsoir,
merci beaucoup pour le travail accompli.
Au plaisir

Cordialement
Céline LEMBERT
Assistante de Service Social - Adhérente ANAS
Numéro RPPS: 10006661713
Association Nationale des Assistants de Service Social

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Steve,
I never responded to this email from back in late January and it is my oversight. I have enjoyed working with you and hope to stay in touch in whatever way. I think you've nurtured and developed an excellent journal and it has been a pleasure to participate in this venture with you. I look forward to getting to work with Bob on future issues. On a related note, do we have any sense of when the next issue will be uploaded?

Best wishes.
Eric Levine, DSW, LMSW, MSW
Touro University Graduate School of Social Work

Authors Needing Reprints

DOI: 10.55521/10-021-204

Stephen M. Marson, Editor

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The International Journal of Social Work Values and Ethics has been receiving requests from our authors requesting to reprint articles that we have published. We have established a policy for permission to reprint. Following are the directions and can be found on our webpage:

https://jswve.org/about/requests-for-reprints/

The International Journal Social Work Values and Ethics (formally known as *The Journal Social Work Values and Ethics*) receives requests to reprint our articles into books and other monographs. IJSWVE will authorize such requests under the following conditions:

- Reprints must acknowledge the publisher of the original article (see below).
- The APA citation of the article be included in a footnote on the first page of the reprint.
- The current URL of the article be included in the citation (see below).
- Updating the original article is permitted.

During its history, *The International Journal Social Work Values and Ethics* has had three different publishers. They include:

- White Hat Communications,
- Association of Social Work Boards,
- International Federation of Social Workers.

To identify the publisher of the article, the following chart is provided.

Publisher	Years	Volumes
White Hat Communications	2004-2012	1-9
Association of Social Work Boards	2013-2021	10-17
International Federation of Social Workers	2021-Present	18-Present

Once the author identifies the year and volume number of the desired article to reprint, the author should go to the article found at https://jswve.org/archives/ and capture the URL in order to insert it in the footnote.

If the author has problems locating any of the required information e-mail: journal@ifsw.org

Changes at IJSWVE and Thank You

DOI: 10.55521/10-021-205

Stephen M. Marson, Editor, and Laura Gibson, Book Review Editor

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This will be the last issue in which Dr. Stephen M Marson will be the editor. Starting in volume 22 issue 1, Dr. Marson will become the associate editor and will be assisting Dr. Robert McKinney in his new role as editor. At that same time, Marson will join the policy and editorial boards.

A great deal of work goes into each issue of the International Journal of Social Work Values and Ethics. All work on our journal is completed by volunteers and no one— including our publisher IFSW — makes a financial profit from the publication. In addition, we have unsung heroes on our editorial board who contribute to the existence of our journal. Because we have a rule that requires our manuscripts to be assessed anonymously, I cannot offer public recognition of their names. I thank them! However, I can publicly announce the names of our hard-working copy editors. Their work is not confidential. For their major contributions to this issue, I must publicly thank:

- Ann Callahan
- Donna DeAngelis
- Veronica Hardy
- Judy Krysik
- Kathleen Hoffman
- Alison MacDonald
- Melissa A Schaub

Thank you to the book reviewers who contributed their valued time and expertise to review books for this issue:

- Stephen M. Marson
- LeAnn Howell
- Peggy Harman

Private Equity Investment and Social Work: Ethical Issues

DOI: 10.55521/10-021-206

Frederic G. Reamer, Ph.D.
Rhode Island College
freamer@ric.edu

Reamer, F. (2024). Private Equity Investment and Social Work: Ethical Issues. *International Journal of Social Work Values and Ethics*, 21(2), 42-63. https://doi.org/10.55521/10-021-206

Abstract

Historically, social work services in the U.S. have been funded by a complex array of public-sector (government) and private-sector funds. A significant percentage of human and social services are sponsored by private equity investors. Private equity entails investment partnerships that use venture capital to buy and manage companies before selling them for profit. Extensive research documents significant abuses and fraud perpetrated by a subset of programs supported or sponsored by private equity investors. The prevalence of private equity investment in human and social services raises fundamental questions about possible clashes with core social work values and ethical standards. The purpose of this article is to provide an overview of private equity investment in human and social services; identify potential benefits and risks that have ethical implications; explore the extent to which private equity investment aligns with core social work values; and use the NASW *Code of Ethics* to guide social workers' efforts to address ethics challenges associated with private equity investment, especially related to issues of informed consent; conflicts of interest and client referral; profess-

sional integrity; administration and practitioners' commitments to employers; unethical conduct of colleagues; dishonesty, fraud, and deception; and social injustice, anti-racism, and social and political action.

Keywords: Ethics, financing, policy, private equity investment, values

Historically, social work services in the U.S. have been funded by a complex array of public-sector (government) and private-sector funds. Some services rely entirely on public-sector funds (federal, state, county, municipal), some rely entirely on private-sector funds (such as private insurance, foundation, and client self-pay), and some rely on a mix of public- and private-sector funds (Jansson, 2019; Specht & Courtney, 1994).

In the private-sector realm, many social and human service programs depend on funds provided by private equity investors (Cendrowski et al., 2012; Kotz, 2015; Morrell & Clark, 2010). Yet, the ethical implications of private equity funding of social work services has not been addressed in the profession's literature. Indeed, a comprehensive search of prominent academic databases (Academic Search Complete, EconLit, PsycINFO, SocINDEX) yielded no publications on the subject of private equity funding of social work services.

In-depth analyses of private equity investment make clear that there may be some benefits to this funding model, along with significant and troubling downsides that run counter to core social work values (Kotz, 2015). The purpose of this article is to review the nature of private equity investment; assess its potential benefits and untoward consequences; explore the relationship between private equity investment and core social work values and ethics standards; and use the NASW *Code of Ethics* (2021) to guide social workers' efforts to address ethics challenges associated with private equity investment.

Private Equity Investment: An Overview

Private equity investment entails partnerships that use venture capital to buy and manage companies before selling them. Investors, many of whom

have high net worth, may be required to commit capital for long periods of time. Often, private equity firms manage their portfolio companies to increase their worth or to extract value before selling the investment years later, ideally for a significant profit. By the time a private equity firm acquires a company, it typically has a plan in place to increase the investment's worth. That could include dramatic cost cuts or a restructuring, steps the company's incumbent management may have been reluctant to take (Cendrowski et al., 2012; Kotz, 2015; Morrell & Clark, 2010).

In the U.S., private-sector investments to support a joint venture date as far back as the Industrial Revolution, when merchant bankers financed such ambitious enterprises as the Transcontinental Railroad, Western Union, Erie Railroad, Union Pacific, and Carnegie Steel Company, among others (Cendrowski et al., 2012). Private equity investment is one key element in the broader role of privatization in human services. Privatization incorporates business principles, methods, and goals into human services and behavioral health organizations. For some of these entities, although not all, profit is a principal aim (Healy, 2002; Kotz, 2015; Wilby, 2008; Zelnick & Abramovitz, 2022).

Private Equity in Human Services and Behavioral Health

Private equity investment in human services and behavioral health is widespread, primarily in the U.S. (DeAngelis, 2022, 2023; O'Grady, 2022). In recent years, venture capital has been invested heavily in outpatient behavioral health offices, psychiatric facilities, telehealth platforms for online therapy, psychotropic drugs, self-help smartphone apps, and other digital tools (DeAngelis, 2022, 2023). Behavioral health startups recently reached private valuations exceeding $1 billion. From 2020 to 2021, the number of behavioral-health acquisitions jumped more than 35% to 153; of those, 123 involved private-equity firms (Lovett, 2022; Safdar & Zuckerman, 2022). Investors invested an estimated $5.5 billion into mental health technology startups globally in 2021, up 139% from 2020 (Safdar & Zuckerman, 2022). In the first three quarters of 2022, private equity deals made up more than

60% of behavioral health transactions (Lovett, 2022). Here are prominent examples, listed chronologically, of private equity firms' ambitious investment in human services and behavioral health programs that employ social workers (Lovett, 2022):

- In 2007, Health Enterprise Partners (HEP) invested in Nashville-based Behavioral Health Centers of America (BCA). In 2021, HEP invested in fast-growing at-home addiction treatment company Aware Recovery.
- In 2011, Webster Equity Partners invested in substance use disorder provider Discovery Behavioral Health. The provider operates more than 145 treatment centers.
- In 2012, Lee Equity invested in Eating Recovery Center. The provider treats people with eating disorders including anorexia, bulimia, binge eating disorder, and other eating disorders. In 2017, Lee Equity sold the provider to CPP Capital advisors.
- In 2014, Shore Capital invested in autism and behavioral health provider The Stepping Stones Group.
- In 2015, Webster Equity Partners announced the acquisition of addiction care provider BayMark Health. It has more than 400 treatment facilities in 37 states and three Canadian provinces. BayMark claims to be the largest provider of opioid use disorder treatment in the U.S.
- In 2018, global private equity investment firm KKR formed Applied Behavioral Analysis (ABA) provider BlueSprig to address the clinical need of pediatric patients diagnosed with autism spectrum disorder.
- In 2021, KKR announced the creation of a new mental health service company called Geode Health. The company partners with behavioral health providers to offer in-person and virtual outpatient mental health treatment to adults and children. It uses digital tools to help track measurement-based care.

- In 2021, the Thurston Group collaborated with outpatient mental health provider Advanced Recovery Concepts to form a new mental health platform called ARC Health.
- In 2022, KKR invested in Brightline, which provides virtual behavioral health care for children, teens and families. The company is valued at roughly $705 million.

Venture capital groups are also investing in the development of smartphone apps and online software tailored to behavioral health. Some apps and software are geared to specific client populations, such as people of color and Indigenous people, LGBTQI+ individuals, and people with serious mental illness. For example, the venture capital firm Telosity has been funding youth-focused apps and technologies; this firm estimates that by 2027, technologies and startup companies related to youth mental health will be worth $26 billion (DeAngelis, 2023).

Private equity investment and stock market investment have been especially prominent in residential treatment programs. For example, as of November 2022, Acadia Healthcare operated a network of 246 behavioral healthcare facilities—including inpatient psychiatric hospitals, specialty treatment facilities, residential treatment centers, and outpatient clinics—with approximately 10,800 beds in 39 states and Puerto Rico (O'Grady, 2022). Investors can track the company's share price on the NASDAQ stock market composite index. The GEO group specializes in the design, development, and delivery of services for private correctional facilities, immigration processing centers, rehabilitation, and other community-based programs. Investors can track the company's share price on the New York Stock Exchange.

Family Help & Wellness (FHW) runs wilderness therapy, residential treatment, and transition programs for teens. FHW provides private pay behavioral health services for adolescents and young adults with 20 programs and almost 800 employees across six states: Utah, Arizona, New Mexico,

North Carolina, Idaho, and Colorado. Family Help & Wellness is owned by private equity firm Trinity Hunt Partners (O'Grady, 2022).

Sevita, formerly the Mentor Network, serves adults and children with intellectual and development disabilities, people recovering from brain injury, children in foster care, and adults and children with autism, among others. Private equity firm Madison Dearborn Partners is a significant investor (Larson, 2022). In 2017, Sequel Youth and Family Services was acquired by Altamont Capital Partners, a private equity firm with over $4.3 billion of capital under management (O'Grady, 2022).

Abusive Practices and Preferential Tax Benefits

Proponents of private equity investment tout several potential benefits, especially related to funding innovations, enhanced management practices, streamlined costs, and nimble flexibility in complex labor markets (Cendrowski et al., 2012; Kotz, 2015). Indeed, there is evidence that private equity investment in behavioral health services has greatly expanded options and choices for people who seek assistance by incentivizing development of smartphone apps, online platforms, and virtual services that clients can access outside of traditional office-based services and operating hours (DeAngelis, 2022, 2023).

However, critics argue that private equity investment can greatly reduce the availability and quality of care and services provided to clients and, in egregious instances, lead to fraud and profound harm (Cendrowski et al., 2012; Kotz, 2015; O'Grady, 2022). Profit-seeking can incentivize personnel and service-delivery cuts to reduce costs. In residential programs, profit-seeking can incentivize recruiting clients who are not appropriate for or in need of the services offered, extending lengths of stay beyond what is clinically warranted or necessary to enhance revenue, and relying on unlicensed staffers to cut personnel costs. A significant number of programs funded with venture capital are unregulated (O'Grady, 2022; Szalavitz, 2006). With regard to programs for youth operating under the auspices of private equity investment, O'Grady (2022) argues that

> Private equity's track record for investing in youth behavioral services is troubling. A pattern of harmful conditions, often related to insufficient staffing and other cuts to expenses, suggests that private equity firms' focus on maximizing profit over short periods of time may come at the cost of children's and teen's safety and well-being. Despite horrific conditions at some youth behavioral health companies, their private equity owners have in some cases reaped massive profits. (p. 21)

In theory, abusive practices can occur in any social service program, regardless of funding sources and whether they are for-profit or non-profit entities. Indeed, some non-profit programs have been linked with notorious abuses (Alberstein & Davidovitch, 2011; Diedrich & Chen, 2022; Reamer, 2021; Szalavitz, 2006). However, extensive research documents significant abuses perpetrated by some programs supported or sponsored by private equity investors (O'Grady, 2022; Reamer, 2021; Reamer & Siegel, 2008; Szalavitz, 2006). Examples in the U.S. include:

- Aspen Education Group was owned by Bain Capital's CRC Health Group, which acquired Aspen in 2006 and held it until 2015, when CRC was acquired by publicly traded Acadia Healthcare. Aspen ran boarding schools, wilderness therapy programs, special needs summer camps, residential treatment facilities, and weight loss programs for youth. Throughout its almost two decades of private equity ownership under various firms, Aspen faced scrutiny for numerous reports of abuse and neglect at its programs. By the time Bain acquired Aspen, the company already faced allegations of abuse and wrongful death of teenage clients after eight years of ownership by private equity firms the Sprout Group, Frazier Healthcare, and Warburg Pincus. Under Bain, these allegations continued until Acadia acquired the company in 2015 and many of its programs were closed, sold, or rebranded ("CRC Health Group," 2014; Stewart, 2007).
- In 2009 the state of Oregon shut down Aspen's Mount Bachelor Academy, a boarding school for struggling teens, following an

investigation by the state's Department of Human Services. The investigation found that students were subjected to sleep deprivation, strenuous work projects, and sexualized role-play in front of peers and adults. In three lawsuits, a total of 51 former students alleged abuse by Mount Bachelor and Aspen. The cases were settled out of court (O'Grady, 2022; Withycombe, 2020).

- In 2009 the state of Oregon Department of Human Services shut down Aspen's SageWalk Wilderness School in Hampton, Oregon after a 16-year-old boy died of a heat stroke while on one of the program's rigorous wilderness hikes (Jung, 2019).
- Equinox, Family Help & Wellness's boys residential treatment center in Hendersonville, North Carolina has been cited numerous times for violations, including a 2021 investigation that cited the company for inadequate training for staff, having unlicensed staff distributing medications, and failing to maintain the facility in a safe and clean manner (O'Grady, 2022).
- A 2017 investigation by the U.S. Senate Committee on Finance found that at least 86 children died in a 10-year period while in the custody of Mentor (between 2005 and 2014). In only 13 of those deaths did the company reportedly conduct an internal investigation (Roston & Singer-Vine, 2017).
- Sequel's Northern Illinois Academy relinquished its license and closed in 2021 following an investigation by a state-appointed monitor finding accusations of battery, isolation, sexual assault, improper restraint, and compliance failures (Wurst, 2021).
- In May 2020, a 16-year-old resident at Sequel-operated Lakeside Academy in Michigan was killed after being restrained by seven staffers for 12 minutes while he struggled to breathe. An investigation by NBC News found records showing that the State of Michigan had substantiated 56 violations at Lakeside Academy since

2018, including multiple instances of inappropriate physical restraints (O'Grady, 2022).

- In December 2020, Sequel Pomegranate in Ohio relinquished the license to its residential behavioral treatment center under the threat of revocation by the state. Ohio regulators found recurring incidents of violent assaults, neglect, and improper restraints of children. As of September 2021, the facility closed permanently (Haeberle, 2021).

Another frequent focus of controversy addresses a macro or public policy issue pertaining to what is known as the carried interest provision in U.S. tax law that allows private equity managers to be taxed at the lower capital gains tax rate on the bulk of their compensation. This provision can make private equity investments in human and social services particularly appealing. Carried interest is a form of compensation paid to investment executives like private equity and venture capital managers. The managers receive a share of the fund's profits—typically 20% of the total—which is divided among them proportionally. The profit is called carried interest, also known as "carry" or "profits interest." That money is considered a return on investment; managers pay a top 20% federal tax rate on those profits, rather than regular federal tax rates of up to 37% that apply to compensation paid as a wage or salary.

That preferential 20% tax rate is the same as "long-term capital gains," which applies to investments like stocks, bonds, mutual funds and real estate held for more than a year. Carried interest accounts for the vast majority of compensation paid to managing partners of private equity funds (Iacurci, 2022). Legislative attempts to tax that compensation as income have not succeeded; in fact, this proposal was dropped from the Inflation Reduction Act of 2022.

Private Equity Investment and Fraud

Some private equity investments in behavioral health have been linked with allegations of significant, sometimes massive financial fraud. A prominent federal court case exposed the dark side of private equity investment in a large behavioral health organization that employed social workers and served large numbers of vulnerable low-income clients (Linton, 2021). This legal case is particularly noteworthy because it resulted in the largest settlement of its kind in the U.S. In 2021, private equity firm and former executives of South Bay Mental Health Center, Inc. (SBMHC) agreed to pay $25 million for allegedly causing fraudulent claims to be submitted to the Massachusetts Medicaid Program, known as MassHealth, for mental health services provided to clients by unlicensed, unqualified, and improperly supervised staff members at clinics across the state.

The Massachusetts Attorney General's Office intervened in a lawsuit initially filed by a whistleblower and former SBMHC employee against SBMHC, a former Chief Executive Officer, and private equity entities H.I.G. Growth Partners, LLC and H.I.G. Capital, LLC, among others. H.I.G. Capital is a private equity firm, and H.I.G. Growth Partners is a subsidiary of H.I.G. Capital. Community Intervention Services Holdings, Inc. (C.I.S.), in turn, was formed and incorporated by H.I.G. Growth Partners. South Bay Mental Health Center, Inc. had operated mental health facilities across Massachusetts.

In legal circles, this is known as a *qui tam* case that involves allegations of "false claims" submitted by an organization to state and federal agencies for reimbursement. The federal False Claims Act (FCA) allows whistleblowers to bring lawsuits against organizations and individuals who defraud the government (many states have similar laws). Qui tam is the abbreviation for the Latin phrase "qui tam pro domino rege quam pro se ipso in hac parte sequitur," meaning "Who sues on behalf of the King as well as for himself." In a qui tam action, a "relator" brings an action against a person or company on the government's behalf. The government, not the relator, is considered the

plaintiff. If the government succeeds, the relator bringing the suit receives a share of the award.

The whistleblower in this case claimed that she voiced concerns to administrators about supervision and hiring practices at SBMHC. She specifically asserted that she raised questions about unlicensed individuals receiving supervision from unlicensed clinicians, a practice which she believed to be in violation of the state's MassHealth regulations. Several SBMHC employees attested that the organization had developed a policy of allowing licensed supervisors to review and sign off on the notes or charts of clinicians whom they were not directly supervising.

The Attorney General's Office alleged that the clinics named in the complaint suffered significant gaps in licensing and supervision of therapists during the relevant time period. The Attorney General's investigation revealed that SBMHC had a widespread pattern of employing unlicensed, unqualified, and unsupervised staff at its mental health facilities in violation of state law. According to the formal complaint filed by the Attorney General's Office and the whistleblower, by submitting fraudulent claims to MassHealth for mental health services provided by unlicensed, unqualified, and unsupervised personnel, SBMHC violated the Massachusetts False Claims Act. MassHealth pays for mental health services provided to MassHealth members by qualified clinicians and counselors who are subject to certain licensure and supervision requirements. Mental health centers that employ those rendering mental health services must comply with certain core supervision requirements set out in applicable regulations.

This settlement resolved allegations that the defendants, including the private equity firms, knew that SBMHC was providing unlicensed, unqualified, and unsupervised services in violation of regulatory requirements and caused fraudulent claims to continue to be submitted to MassHealth by failing to adopt recommendations to bring SMBHC into compliance. Private

equity firm HIG held a majority of seats on the company's board of directors.14

Private Equity Investment and Social Work Values

The prevalence of private equity investment in human and social services raises fundamental questions about possible clashes with core social work values and standards that are central to the NASW *Code of Ethics*. Key questions concern the implications of private equity investment with respect to issues of informed consent; conflicts of interest and client referral; professional integrity; administration and social workers' commitments to employers; unethical conduct of colleagues; dishonesty, fraud, and deception; and social injustice, anti-racism, and social and political action. What follows is an overview of the ways in which NASW *Code of Ethics* standards provide a constructive and tailored roadmap for social workers who want to address ethical concerns associated with private equity investment.

Informed Consent

Many human service and social service programs operated under the auspices of private equity groups employ social workers as clinicians, supervisors, and administrators (Reamer & Siegel, 2008; Zelnick & Abramovitz, 2020). When feasible, these practitioners have a moral obligation to explain to clients and potential clients the potential benefits and risks associated with their programs that may be linked with the private equity investment financing model (Reamer, 2024). According to the NASW *Code of Ethics*,

> Social workers should provide services to clients only in the context of a professional relationship based, when appropriate, on valid informed consent. Social workers should use clear and understandable language to inform clients of the purpose of the services, risks related to the

[14] The author served as a publicly identified expert witness in this federal court case on behalf of the plaintiffs.

> services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions. (standard 1.03[a])

Informed consent is especially important when clients are mandated to enroll in programs (e.g., due to a court order). According to the NASW *Code of Ethics*, "in instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service" (standard 1.03[d]). Admittedly, in some instances social workers would not be able to comply with this standard, for example, practitioners who work in for-profit prisons and immigration detention centers funded by venture capital. In these instances, clients do not have a right to refuse services (incarceration and detention) comparable to the right of clients who seek services voluntarily. However, within the prison or detention facility inmates and detainees may have a right to refuse certain elective services, such as counseling or participation in a substance use disorder treatment program.

Conflicts of Interest and Client Referral

Social workers may be employed in programs that seek to maximize profit for private equity investors. A profit motive may pressure social workers who have marketing and admission responsibilities to recruit clients whose needs may be better served by other programs and to extend clients' lengths of stay unnecessarily to enhance revenue. Social workers are obligated to avoid such conflicts of interest. According to the NASW *Code of Ethics*,

> Social workers should be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. Social workers should inform clients when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the clients' interests primary and protects clients' interests to the greatest extent possible. In some cases, protecting clients'

> interests may require termination of the professional relationship with proper referral of the client. (standard 1.06[a])

Social workers employed in programs under the auspices of private equity investors who have evidence that clients' needs would be better served by other programs have an ethical obligation to refer them. According to the NASW *Code of Ethics*, "social workers should refer clients to other professionals when the other professionals' specialized knowledge or expertise is needed to serve clients fully or when social workers believe that they are not being effective or making reasonable progress with clients and that other services are required" (standard 1.16[a]).

Professional Integrity

Social workers who consider employment opportunities in programs operating under the auspices of private equity firms should thoroughly assess the extent to which potential employers' policies and protocols align with social work values and ethical standards. Social workers' judgments about whether to accept employment in these settings are decisions of conscience. According to the NASW *Code of Ethics*, "social workers should not allow an employing organization's policies, procedures, regulations, or administrative orders to interfere with their ethical practice of social work. Social workers should take reasonable steps to ensure that their employing organizations' practices are consistent with the NASW *Code of Ethics*" (standard 3.09[d]) and "social workers should uphold and advance the values, ethics, knowledge, and mission of the profession" (standard 5.01[b]). Further, social workers should "monitor and evaluate policies, the implementation of programs, and practice interventions" (standard 5.02[a]).

Administration and Commitments to Employers

Social workers who have evidence that programs that employ them have policies and protocols that violate social work values and ethical standards because of private equity investment have a duty to bring their concerns to the attention of people in positions of authority and seek constructive

change. This is especially important for social workers who serve in administrative positions, including in organizations that serve voluntary clients and those that serve involuntary (e.g., court-ordered) clients. According to the NASW *Code of Ethics*,

> Social work administrators should take reasonable steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the NASW Code of Ethics. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the Code. (standard 3.07[d])

More specifically, social workers who have evidence that colleagues are engaging in unethical conduct linked with private equity investment have a moral obligation to expose and challenge the misconduct and seek meaningful reform. According to the NASW *Code of Ethics*, "social workers who believe that a colleague has acted unethically should seek resolution by discussing their concerns with the colleague when feasible and when such discussion is likely to be productive" (standard 2.10[c]). Further, "when necessary, social workers who believe that a colleague has acted unethically should take action through appropriate formal channels (such as contacting a state licensing board or regulatory body, the NASW National Ethics Committee, or other professional ethics committees)" (standard 2.10[d]).

Dishonesty, Fraud, and Deception

Social workers employed in programs sponsored by private equity investors must be scrupulous in their efforts to avoid any participation in dishonest, fraudulent, and deceptive practices, especially related to marketing and recruitment (for example, when social workers are employed in residential treatment programs that actively seek clients who have generous insurance benefits or the ability to pay out-of-pocket). Social workers should not misrepresent employers' policies and protocols or mislead potential clients with respect to the availability of services, quality of services, staffers' qualifications and training, discipline protocols, and lengths of stay. According

to the NASW *Code of Ethics*, "social workers should not participate in, condone, or be associated with dishonesty, fraud, or deception" (standard 4.04).

Social Injustice, Anti-racism, and Social and Political Action

Human service and social service programs supported by private equity investment seek to maximize profit. As a result, some programs limit themselves to clients whose services are covered by private health insurance policies with comprehensive benefits, whose reimbursement rates typically are higher than Medicaid reimbursement rates, or who have the ability to pay for services out-of-pocket (Artiga, Hill, & Damico, 2022; Harker, 2021; Yearby, Clark, & Figueroa, 2022). Social workers may be stymied in their efforts to locate quality services and programs for low-income clients of color who are not covered by generous health insurance benefits or who do not have the ability to pay for services out-of-pocket. Ideally, social workers would engage in assertive anti-racist and nondiscriminatory advocacy efforts to expand funding and coverage for this client population, directed especially at key stakeholders and policy officials in government agencies and those employed by private-sector insurers. According to the NASW *Code of Ethics*, "social workers should act to expand choice and opportunity for all people, with special regard for vulnerable, disadvantaged, oppressed, and exploited people and groups" (standard 6.04[b]). More specifically, "social workers should not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of race, ethnicity . . ." (standard 4.02).

Further, social workers have an ethical duty to prevent program-based abuses and to seek reasonable governmental oversight of programs sponsored by private equity investors. Meaningful legislation and regulation can go a long way toward preventing a wide range of financial, emotional, and physical abuses. For example, in 2021 social workers and other professionals collaborated with media personality, businesswoman, model, and entertainer Paris Hilton, a former client in a Utah residential program for

struggling teens, to lobby successfully for legislation in that state designed to regulate and promote safety in programs for this client population.

Also, U.S. social workers and other advocates have collaborated with members of Congress to introduce federal legislation to enhance protections in such programs, many of which are supported by private equity investors. For example, legislation sponsored by U.S. Representative Ro Khanna of California and Senator Jeff Merkley of Oregon would create a bill of rights to protect youth who are in congregate care facilities. Those rights would include being protected from abuse and neglect, freedom from physical and chemical restraints, and the right to be free from abusive or traumatizing treatment by staff or other youth. The legislative proposal also emphasizes data collection and would make federal funding available for states to mend systemic issues (Miller & Fuchs, 2021). Social workers' duty to engage in advocacy to prevent harm and injustice is cited throughout the NASW *Code of Ethics*' mission statement, principles, and ethical standards.

Conclusion

Social work is unique among the helping professions in that the mission statement in the NASW *Code of Ethics* highlights explicitly practitioners' responsibility to address the unique needs of people who are "vulnerable, oppressed, and living in poverty." The research record documents that the proliferation of private equity investment in human and social services can limit the availability of services to vulnerable populations, especially populations of color, compromise the extent and quality of available services, and cause significant emotional, physical, and financial harm.

Key elements of the NASW *Code of Ethics* provide a much-needed roadmap for social workers who are concerned about possible detrimental ramifications of private equity investment in human and social services. The code highlights critically important ethical concerns, standards, and guidelines that social workers can use to prevent harm, advocate for needed reforms, and expand programmatic options, especially related to issues of informed consent; conflicts of interest; professional integrity; administration

and practitioners' commitments to employers; unethical conduct of colleagues; dishonesty, fraud, and deception; and social injustice, anti-racism, and social and political action.

Social work as a profession is uniquely positioned to identify and address challenges associated with private equity investment in human and social services. Social work's venerable hallmark is its simultaneous concern about individual well-being and the environmental, structural, economic, and policy phenomena that affect people's lives. Social work's principal virtue is its sustained concern about individuals' private troubles and the public issues that affect them. Indeed, that is the focus required to fully understand and confront potential harms caused by private equity investment in the human and social services.

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Trustworthiness versus Trust: An Important Distinction with Significant Ethical Implications for Social Work

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Erlene Grise-Owens, Ed.D., LCSW
Partner, The Wellness Group, ETC
drerlene@gmail.com

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Abstract

Trust is increasingly viewed as a key aspect of societal functioning—from micro to meta. This article explores the constructs of trust versus trustworthiness, and their significance for social work. It critically considers these constructs in general and, then, more specifically in social work practice and the profession as a whole. The dominant paradigm and discourse prioritize trust as the primary aim, with vulnerability being a parallel expectation. That is, trustworthiness is secondary—or not considered, at all. In this dominant framing paradigm, those being expected to trust must make themselves vulnerable.

Through use of both individual and universal stories, and grounded in the scholarship on this topic, the author examines the ethical implications of having trust as a dominant goal. The epistemic and pragmatic implications of this goal are considered, especially within ubiquitous power differentials. This dominant paradigm is problematic in relation to social work priorities, such as social justice and human rights. In the dominant frame, building trust is a common metaphor. Informed by critical reflection and social work ethics, the

author proposes a new narrative with a framing metaphor of cultivating trustworthiness. This paradigm shift has important implications for social work practice and the profession as a whole..

Keywords: Trustworthiness, trust, ethics, values, qualitative analysis

"You're just going to have to trust me."

The university provost delivered this directive to me toward the end of a meeting in which I had shared significant, ongoing issues. These concerns included a pattern of systemic, institutional racism and encompassed matters related to basic psychological and physical safety. Colleagues and I had been pursuing these concerns for some time. As a full, tenured professor who had been at the university for almost two decades, I believed I had an ethical responsibility to use my privileged status to advocate and contribute. As a white person, I believed I had the moral obligation to use my positionality to challenge white supremacy. Further, as a long-time social worker, I believed I had a particular ethical imperative to pursue justice and human rights—including in my own profession and workplace.

Yet, at every level—including my meeting with the provost—University administration continued to ignore, downplay, and sweep under the rug these concerns. In some instances, colleagues and I were bullied, gaslit, and punished. A general atmosphere of distrust permeated the University. It was a case study of "cordial hypocrisy," which Solomon and Flores (2003) coined as "the strong tendency of people in organizations…to pretend there is trust when there is none, to be polite in the name of harmony, when cynicism and distrust are active poisons eating away at the very existence of the organization" (p. 4).

To the provost's assertion, "trust me," I responded, "I have learned that trustworthiness is a much more pertinent goal than trust. For reasonable trust to occur, trustworthiness has to be established." I elaborated briefly on what I meant. I offered, "Let's check back in a few weeks to see how trustworthiness is developing." Then, I thanked her for the meeting. I reiterated my commitment to addressing these concerns, as well as my hope for and

support of her leadership in doing so. After a bit of silence, we exchanged perfunctory comments to close the meeting.

"*As of today, your employment with Spalding University has officially ended.*"

A few weeks after the "trust me" meeting, this sentence began the brief letter signed by the university president and provost. The letter came by certified mail to my home on a Friday afternoon. Two colleagues and I had met that very morning with the Faculty Senate regarding the concerns I'd discussed with the provost. I had no warning; no process was followed; no reason was given for my termination. My firing precipitated an investigation by the American Association of University Professors. AAUP's (2017) report thoroughly documents the background, context, and rationale for their censure of the University. (At this writing, the University remains censured.)

I have not spoken with the provost since our "trust me" meeting. But, if I do—trust me! —I will remind her of our meeting. I will clarify that, indubitably, trustworthiness has not been established.

Overview: Re-storying Trustworthiness as Paramount

In this article, I thread this particular "trust me" story throughout to illustrate salient, universal points. I invite you to think about one of your stories in which the distinction between trust and trustworthiness is a central theme. For this exercise, identify a work-related scenario; it may pertain to clients, causes, colleagues, or other contexts. Like mine, it may pertain to your organization and its leadership. I tell my "trust me" story because we all have these stories, both individually and collectively.

By telling my story and encouraging your story, I hope to contribute to creating a larger narrative wherein trustworthiness is recognized as a primary consideration, rather than ancillary to trust. As such, this article draws upon narrative and storytelling (e.g., Atkinson et al., 2019; Burack-Weiss et al., 2017) as empowering methodologies that are particularly relevant in efforts to challenge harmful dominant paradigms. The article begins with a

broad-based exploration of the dominant story or paradigm that presents trust as paramount and trustworthiness as ancillary or invisible. Then, the article focuses on how this discussion applies to social work, as an ethical consideration, and proposes a re-story.

I purport that a dominant emphasis on trust, which diminishes or dismisses attention to trustworthiness, is not innocuous; rather, it is significantly problematic. Especially through a social work lens, this emphasis on trust can be foolhardy, dangerous, and harmful. Thus, this topic is an important ethical consideration that merits more explicit critique and consistent attention. Toward that purpose, I propose that instead of *building trust* as the dominant frame, we *re-story cultivating trustworthiness* as the primary aim.

"Building Trust": A Just Critique of This Dominant Framing

"Trust" is a topic of growing interest in myriad contexts. Ma et al. (2019) provide a helpful metanalysis to "enable scholars who have not followed the trust literature to identify issues and trends" (p. 2). These authors remark upon the burgeoning studies about trust as indication of its expanding importance. For instance, amongst other indicators, they point out that the number of published studies of trust within teams, alone, swelled from less than 10 prior to 2000 to over 100 by 2015.

The importance of this topic is reinforced by emerging findings about the impact of this construct. Increasingly, trust is linked with an array of positive associations and outcomes highly desirable for functioning and well-being (e.g., Simon, 2020a). For instance, in organizations, trust is associated with employee satisfaction, engagement, investment, and performance (e.g., Coughlan, 2021; Feltman, 2021; Lencioni, 2002). It is linked with greater organizational commitment, identification, and proactive behavior (e.g., Ma et al., 2019; Parker et al., 2006; Schaubroeck et al., 2013). These linkages contribute to higher morale, lower turnover, cooperative teamwork, and greater productivity (e.g., Coughlan, 2021; Covey & Merrill, 2018). Trust affects social and personal dynamics—from group process, to interpersonal

negotiations, familial/personal interactions, and other human exchanges (e.g., Balliet & Van Lange, 2013; Ma et al., 2019; Simon, 2020a). A high level of trust is characterized by positive cognitions, such as hope, and high satisfaction in relationships (e.g., Allen, 2022; Brown, 2018; Covey & Merrill, 2018).

Consistently, the literature defines trust as "confidence in another party and a willingness to be vulnerable to the party" (Ma et al., 2019, p. 3). Coughlan (2021) asserts that trust is a "relatively complex psychological state that arises in relationships characterized by dependence and risk" (p. 1). Notably, "vulnerability" is persistently and explicitly identified as an integral aspect of trust (e.g., Brown, 2018; Feltman, 2021; Ma et al, 2019).

The preponderance of study and attention to this phenomenon positions "trust" as the primary focus (e.g., Allen, 2022; Simon, 2020a). Attention to the construct of "trustworthiness" is notable in its absence—or, if present, typically treated as ancillary. In 1995, Mayer and colleagues explicated a now classic model for trustworthiness in which they identified three components of trustworthiness as benevolence, ability, and integrity. In their model, benevolence is generally defined as desiring good for others; ability is construed as competence; and integrity is explicated as adherence to principles, such as truthfulness and dependability. This model is often cited when trustworthiness is mentioned. However, trustworthiness is typically treated as a secondary consideration to the main topic, trust (e.g., O'Neill, 2013; Potter, 2020).

The dominant framing focuses on trust as the primary aim. Oftentimes, the metaphor of "building trust" is used to convey that trust is the ultimate construction. This framing sets up an expectation of vulnerability in order to achieve this superordinate aim.

What does this discussion about trust vs. trustworthiness have to do with social work practice and the social work profession? More specifically, how is this topic an ethical concern? Consider what social workers do. One would be hard-pressed to name any social work role, responsibility, or relationship that does not involve trust. Social work involves working with clients in a micro role, facilitating communication in mezzo intersections,

advocating for causes in macro contexts, and navigating the integrated aspects required by our social work mission of pursuing social justice and human well-being. In all these facets, trust vs. trustworthiness is a crucial consideration for our profession (e.g., Healy, 2017).

One of the defining features of a profession is its willingness to establish ethical standards to guide practitioners' conduct. Ethical standards are created to address ethical issues in practice and to provide guidelines for determining what is ethically acceptable or unacceptable. As Reamer (2022) asserts, "To practice competently, contemporary professionals must have a firm grasp of pertinent issues related to ethical dilemmas and ethical decision-making. This knowledge enhances social workers' ability to protect clients and fulfill social work's critically important, values-based mission" (p. 117). In this context, if the pervasive, ultimate aim is posed as "building trust," then an ethical imperative is to clarify what that means and critically consider its ramifications.

When Trust is the Aim

My "trust me" story illustrates a common misunderstanding about trust. It crystallizes a prevalent phenomenon in organizations—and, actually, in all levels of relationships, personal and professional. Trust is touted as a desired goal and indicator of a healthy work environment and relationship. Often, implicitly and subtly, the message is: If you do not trust, you are not a team player. You are not a good colleague. You are not a community-builder. You are not loyal to the organization or relationship. If you do not trust, *you* are the problem.

As encapsulated in my story, trust is often used as a bludgeon to subdue dissent and a muzzle to silence critique. In a case of irony, in my meeting with the provost, she shared that a favorite resource was *The Five Dysfunctions of a Team*. I acknowledged I had not read the book, but that my colleague, Laura, had given me a copy, because she used it in her organizational leadership consultations. Notably, Laura, who is Latina, was an assistant professor and one of my social work colleagues most harmed in the

toxic dynamics pervasive at the university. Laura was also a courageous voice in our joint advocacy efforts to address the toxic culture. The provost was aware of this dynamic.

In further irony, perusing the book later, I learned that Lencioni (2002) lists Dysfunction 1 as *Absence of Trust*. Lencioni declares, "Trust is at the heart of a functioning, cohesive team. Unfortunately, trust is used—and misused—so often that it has lost some of its impact." He elaborates, "…trust is the confidence…that…intentions are good and that there is no reason to be protective or careful…" (p 195). Lencioni provides strategies to use in building trust and advises that vulnerability is key in these efforts. Notably, Lencioni does not discuss trustworthiness.

Similarly, as another popular example, in *The Thin Book of Trust*, Feltman (2021) defines trust as "choosing to risk making something you value vulnerable to another person's actions" (p. 9). Whilst Feltman briefly mentions trustworthiness, it is—again—consistently treated as a secondary topic. Trust is paramount. Notably, again, the theme of vulnerability is persistently pronounced as the necessary element for trust to occur.

Stephen Covey and Rebecca Merrill's (2018) bestseller, *The Speed of Trust—The One Thing that Changes Everything* serves as a quintessential example of this dominant narrative. The authors declare a "crisis of trust" (p. 10). Emphasizing the ubiquity and urgency of this crisis, the authors assert that "trust…undergirds and affects the quality of every relationship, every communication, every work project, every business venture, every effort…It changes the quality of every moment and alters…every future moment of our lives—both personally and professionally" (pp. 1-2). Yet, a content analysis reveals that the construct *trustworthiness* is not given even cursory consideration. In this 374-page tome with titles and headings liberally used on every page, trustworthiness does not merit mention. Furthermore, the term *trustworthiness* does not appear in a detailed index of terms.

Interestingly, vulnerability does not appear in this book. Unlike more prominent definitions that presume vulnerability, Covey and Merrill (2018) define "trust" as "confidence" and the opposite, "distrust" as "suspicion." (p. 5). This inattention to both trustworthiness and vulnerability may be

attributable to the book's primary intended audience of managerial leaders (i.e., high-level power positions). As I discuss below, trust—with presumed vulnerability and inattention to power differentials—is typically presented in terms of subordinates trusting. Remarkably, in summarizing the benefits of responding to this crisis of trust, the book concludes "leaders everywhere" are recognizing that trust is "the ultimate currency" (p. 343).

Social work seems to largely follow this dominant narrative. For instance, classical studies on trust—such as Luhmann (1979) and Seligman (1997), which inform the profession—place trust as primary. At this writing, a keyword search of several databases—including this journal—revealed scant attention to trustworthiness. As one prominent example, Brene Brown is perhaps the most widely-known contemporary social work voice, on topics such as leadership and complementary human dynamics. Her influence reaches a broad range of sectors and a growing global audience. In her best-selling book, *Dare to Lead*, Brown (2018) dedicates an entire section to "Braving Trust." Brown briefly mentions trustworthiness. However, Brown's dominant focus is on trust. As an important indicator of its lack of attention, the term *trustworthiness* does not even merit mention in the book's detailed index. Like other dominant sources, Brown emphasizes repeatedly that trust requires vulnerability.

Healy (2017) offers a significant exception in the social work discourse. In a pivotal essay, explicitly asserting a crisis of trust, she issues a clarion call for social work to become a trustworthy profession. Emphasizing that social work is a relationship-based profession grounded in particular values and ethics, Healy discusses how the profession must prioritize trustworthiness. She calls for reasserting professional purpose, committing to professional excellence, and exercising courage in advocacy and addressing abuses of power.

When Trustworthiness is the Aim

Amidst a broader culture and a professional context of a "crisis of trust," in the university's climate of "cordial hypocrisy," I was experiencing the parody of "trust as currency." Fortunately for me, though less so for the provost, I had not yet read the dominant advice that frames trust as the presumed aim and vulnerability as the necessary starting point. However, fortuitously, I *had* listened to the venerable Onora O'Neill. A British Baroness and member of the House of Lords, O'Neill is a renowned philosopher who focuses on international justice and human rights. O'Neill's (2013) TEDx talk "What We Don't Understand about Trust" is captivating and paradigm-shifting. In my "trust me" meeting with the provost, in a superficially collegial way, we shared resources. When I clarified the importance of trustworthiness, I recommended the provost consider O'Neill's work.

O'Neill (2013) succinctly and effectively makes the case that the aim "have more trust" is a "stupid aim." She asserts that putting trust before trustworthiness is consequentially problematic. "Trust is the response. Trustworthiness is what we have to judge," she clarifies. Thus, the aim should be trustworthiness. Thus, the task becomes—rather than building more trust—to ensure evidence of trustworthiness. O'Neill concludes, "We need to think much less about trust…much more about being trustworthy, and how you give people adequate, useful, and simple evidence that you're trustworthy."

As noted earlier, Mayer and colleagues (1995) identified benevolence, ability, and integrity as elements of trustworthiness. Yet, consistently in research and practice, trustworthiness is treated as secondary to trust, which focuses on vulnerability as a core requirement. Allen (2022) cogently presents psychotherapy as one of myriad examples of disciplines that ignore trustworthiness—with serious consequences. Allen writes that *trust* is generally considered essential for effective therapeutic relationships. Allen highlights that the emphasis—rooted in the power differential—is typically placed on how clients need to trust the therapist; the client is problematic when they do not trust. He observes, "But trusting makes no sense unless

the trusted person is trustworthy, and trustworthiness is almost entirely neglected in the psychotherapy literature" (p. xxv). After decades in the field, Allen purports that "trustworthiness [should be] the overarching aim of…psychotherapy" (p. 49). Similar to O'Neill's (2013) corrective, Allen asserts, "With trustworthiness, depending on others is a solution, not a problem"; the aim is to "trust well (in proportion to trustworthiness) and to distrust well (in proportion to untrustworthiness)" (p. 151).

Likewise, Potter (2002) develops this paradigm-shift. In particular, she emphasizes that the constructs of power, equity, and justice must be critically considered. A philosopher and feminist theorist, Potter contends that relationships of trust should take into account power differentials. She explains how the traditional prioritization of trust—which typically ignores attention to power—fosters the privileged exploiting those in vulnerable social positions. She writes, "So, while it is not one's moral responsibility to trust others, it is one's responsibility to cultivate proper trust" (p. 12). Thus, she maintains that a just, moral, and ethical approach must place trustworthiness as primary. In this shift, using a virtue theory lens, Potter lays out a framework for focusing on trustworthiness as necessary for creating moral character, healthy relationships, equitable cultures, and, ultimately, a just world. As Potter summarized, (Personal Communication, May 9, 2022), "Most of the literature on trust does not ask the question: Why should I trust you? What makes you worthy of my trust?"

Significantly leading in this discourse, *The Routledge Handbook of Trust and Philosophy* (Simon, 2020a) offers progress in exploring those questions posed by Potter and develops the paradigm-shift. The comprehensive volume contains 31 entries written from global perspectives and multi-disciplinary lenses ranging from sociology, law, economics, nanotechnology, and others. In introducing the volume, Simon (2020b) explicitly asserts the need to correct the dominant narrative that places trust as paramount and trustworthiness as secondary. Then, in the first chapter, "Questioning Trust," O'Neill (2020) articulates her thesis described above: Trust is a stupid—and potentially dangerous—emphasis; trustworthiness is the more important aim. O'Neill concludes, "Rather than inflating and expanding formal

systems for securing compliance and accountability yet further, it may be more effective to build and foster cultures that support trustworthiness and capacities to judge trustworthiness" (p. 26).

This theme is further explicitly developed in the *Handbook's* next chapter, "Trust and Trustworthiness," in which Scheman (2020) emphasizes the crucial points that trust and trustworthiness occur in contexts of and are impacted by power differentials. Given these important considerations, oftentimes, distrust may be reasonable and wise. Scheman concludes that decisions regarding trustworthiness and trust must take into account positionalities in relation to diversity and power differentials.

Various other entries underscore this paradigm shift. Here are some examples particularly pertinent for social work. In their entry, Nickel and Frank (2020) explicitly counter the paternalistic approach of medicine as demanding trust of the physician and instead emphasize signaling trustworthiness as imperative professionalism. Likewise, in "Trust and Food Biotechnology," Meijboom (2020) frames trustworthiness as practical and strategic, as well as moral and ethical. He concludes the main focus is not on how to change consumers so they will trust, but "what conditions the trustee has to fulfill to be worthy of such trust" (p. 386).

In other entries, Alfano and Huijts (2020) provide a macro lens in "Trust in Institutions and Governance." These authors articulate the concept of rich global trustworthiness; that is, a diverse expanse of stakeholders must have a meaningful voice in decisions; furthermore, responsiveness to power differentials—e.g., dependency, vulnerability—is essential. They succinctly conclude, "So, while trust may often be a good thing, it needs to be earned" (p. 268). Taking a systemic-mezzo lens, Potter (2020) emphasizes the important intersectional impact of the personal experiences and contextual considerations—e.g., systemic oppression, justice, reparations, and so forth—on interpersonal trust and trustworthiness. Then, Clement (2020), through a micro-lens, considers everyday interactions and the evolution of trust developmentally. He cautions that the trust hormone, serotonin, tends to assign trustworthiness to those perceived as similar. Such biases require intentional critique and epistemic responsibility.

Finally, two companion entries offer a meta-lens perspective particularly crucial for social work. A meta-lens engages, "global social aspects that both overarch and interact with macro, mezzo, and micro practice…promoting the expansive worldview necessary for a response to relevant practice realities" (Grise-Owens et al., 2014, p. 47). In his chapter, Medina (2020) writes, "Epistemic injustices are committed when individuals or groups are wronged as knowers; that is, when they are mistreated in their status, capacity and participation in meaning-making and knowledge-producing practices" (p. 68). Medina develops the crucial thesis that people are excluded, marginalized, and mistreated based on trust, distrust, and trustworthiness—and, critically, who has the power to discern or demand these.

Likewise, Frost-Arnold (2020) underscores that trust and distrust are shaped by prejudices and systemic oppressions, which foster epistemic injustice and violence. She asserts that individuals and institutions have epistemic responsibilities for developing competence in being trustworthy and signaling that trustworthiness—particularly in relations and situations with power differentials. This competence involves a host of skills and steps at all levels. For instance, Frost-Arnold proposes that educational institutions have the responsibility to "restructure curricular priorities and provide resources to teachers to help them unlearn their ignorance and develop the skills to signal [trustworthiness] effectively with diverse groups of students" (p. 73).

In summary, these considerations lead to better questions pertaining to trust-trustworthiness and trust: Whose accounts are believed, trusted, trustworthy? Whose knowing is privileged, trusted, trustworthy? Who has the power to demand trust? Who is expected to become vulnerable? How is trustworthiness engendered and earned? These considerations of trust and trustworthiness have comprehensive philosophical and pragmatic implications for the practice of social work. These questions must guide all our efforts toward becoming trustworthy.

Social Work Ethics and Trustworthiness

Explicitly consider this proposed paradigm shift toward trustworthiness as the central aim in the context of social work ethics. Marson and McKinney (2019) explain that social work codes of ethics (COEs) are integral to the profession. COEs serve to distinguish a professional identify. They explicate core values, guide professional behavior, and protect the social worker and social service recipients from potentially unethical behaviors of social workers. Given these parameters, an emphasis on trustworthiness is exceptionally congruent with social work ethics.

The International Federation of Social Workers' (International Federation of Social Workers [IFSW], 2014) definition of social work encapsulates core ethical principles. Consider this definition in relation to the above discussion proposing the paradigm-shift of trustworthiness as the aim—rather than trust assumed or demanded. Core social work principles include empowerment, liberation, social justice, human rights, collective responsibility, respect for diversities, and wellbeing. Trustworthiness is essential for these phenomena to occur, and, iteratively, fosters growth of them. In stark contrast, promoting trust as an expectation and vulnerability as a requirement usually stymies them and, too often, exacerbates their opposites—i.e., disempowerment, injustice, and so forth. That is, a trust emphasis typically (albeit sometimes subtly) ignores, and often exploits, power differentials. In contrast, social work seeks to eradicate unjust inequity. In these endeavors, vulnerability should not be viewed as unquestionably necessary, but rather as potentially dangerous, particularly for persons in historically disenfranchised groups.

Furthermore, the key elements of trustworthiness explicitly align with the fundamental emphases of the profession of social work. That is, benevolence, competence, and integrity are crucial social work values. In a particularly compelling overlap, integrity is typically defined as *being trustworthy*. For instance, in explicating the core value of integrity, the United States National Association of Social Workers (National Association of Social Workers [NASW], 2021) *Code of Ethics* expresses the guiding principle for this value as

"Social workers behave in a *trustworthy* [emphasis added] manner." (p. 6). Similarly, the NASW *COE* explicitly identifies competence as a core value (p. 6). Benevolence—defined as desiring good for others—is an overarching mission of social work (e.g. social justice, liberation, well-being). This mission is further illuminated in complementary core values, such as service, the value of human relationships, dignity and worth of the person, and importance of human relationships (e.g., IFSW, 2014; NASW, 2021).

Hence, social work is well positioned to take a leading role in promoting ethical attention to trustworthiness (Healy, 2017). And, I purport that—given our mission—the profession has an ethical responsibility to do so. This role and responsibility apply both within and external to the profession.

ReFraming: Setting A Solid Foundation Before Putting on the Roof

For much of the world, for social work specifically, and certainly the populations and causes that social work predominantly serves: Focusing on trust is—to quote Baroness O'Neill—a "stupid aim." Furthermore, especially in power differential relationships, expecting vulnerability without the establishment of trustworthiness is problematic. Critical literature and social workers' practice wisdom amply support (albeit, often implicitly) this observation.

As the above discussion explicated, distrust may be a reasonable and wise course. Kendall (2020) cogently crystallizes this dynamic in *Hood Feminism—Notes from the Women That a Movement Forgot*. Kendall relates how her lived experiences taught her to "distrust." She explains, "Being skeptical of those who promise they care but do nothing to help those who are marginalized is a *life skill* [emphasis added] that can serve you well when your identity makes you a target" (p. xiii).

To summarize: Distrust is a life skill, especially for those who are marginalized and targeted. Building trust is a "stupid aim." Trusting is not a moral responsibility; instead, cultivating trustworthiness is an ethical responsibility. Given these considerations: What is the epistemic and

pragmatic role and responsibility in trust-trustworthiness? As social workers, is it ethical to presuppose trust and require vulnerability before trustworthiness is established? I contend the answer is "No." Instead, social work needs to re-story trustworthiness.

I propose an initial reframe of the dominant framework that presents trust as the foundation and vulnerability as the starting point. Using a building metaphor of a home construction site, I suggest that trustworthiness—comprised of integrity, competence, and benevolence—is the solid foundation that must be laid first. Then, building on that metaphor, power is the connective energy—i.e., electrical wiring and the plumbing—that makes the house functional. In this metaphor, vulnerability is the walls, doors, and windows, because vulnerability requires both openness and boundaries. Vulnerability is reasonable and advisable only when connected with some foundation of trustworthiness and energy of shared power. Otherwise, this vulnerability creates—at minimum—unproductive, dysfunctional dynamics. And, in toxic cultures/scenarios, this vulnerability contributes to unsafe and sometimes dangerous situations.

Finally, as a capstone rather than starting point, trust is the finished aspect that keeps out the elements that can harm and diminish the structure (i.e., relationship, organization). But, if we build by starting with the roof, it is doomed to fail. The structure is simply not going to function in the long-term. Actually, without a foundation, the roof is dangerous; it will collapse on itself. Anyone seeking its shelter will be crushed beneath it. Without wiring, plumbing, walls, doors, and windows, the roof becomes useless. It may be decorative. Even more problematic, it may be used as a cover up for a lack of substance and structure. It can be a decorative dome that makes dysfunction seem to magically disappear, whilst those left under the heavy weight are suffocated.

Ethical Implications: Re-Righting the Stories to Center and Cultivate Trustworthiness

"I'm going to have to show you that I am trustworthy."

Imagine how differently my story would be, if the provost made that assertion and activated it. Reflect on your story I asked you to imagine as we began this conversation. Imagine how differently your story would be if trustworthiness were the aim, rather than trust being the demand. Consider how differently countless stories would be written if the components of trustworthiness were presumed to be central and essential—rather than trust as the dominant aim.

When trust is the presumed priority, unethical and incompetent leaders and other persons with disproportionate power can use this assumption to bully, shame, control, punish, gaslight, and manipulate. In my story, the provost commanded, "trust me." This scenario is common. In these scenarios, we—the ones being commanded—often feel the burden of trust. We acquiesce and feel stressful cognitive dissonance from the unquestioned, implicit expectations: Good colleagues, team members, people trust. Respectful employees trust their leaders. If I do not trust, I am the problem in this equation. I need to make myself vulnerable in order for trust to be built. Emphatically, the consequences of fulfilling these expectations are not innocuous; they are consequential. Cultures of cordial hypocrisy are propagated, which breeds dangerous toxicity. In these contexts, too often, people are punished if they do not adhere to the cordial hypocrisy that requires vulnerability before competence, integrity, and benevolence.

In contrast, trustworthiness as the starting point keeps the onus where it belongs: Integrity, competence, and benevolence of those pursuing trust. In these scenarios, the burden is the proof of trustworthiness. Thus, the expectations change: Good colleagues, team members, leaders, people engender trustworthiness. Wise people critically assess trust-worthiness and

operate according to the evidence and insights. Trustworthiness is cultivated, rather than trust commanded. Trust is earned through proven trustworthiness, not expected through demanded vulnerability. Leadership and other aspects of power and privilege inherently include a responsibility for competence in cultivating and signaling trustworthiness.

I began this piece with my "trust me" story. I invited you to think of your similar story as you read this article. Now, I invite further consideration of how our relationships, communities, organizations, other systems—as well as our individual selves—might be affected by changing how we frame this dynamic. What if, instead of a framework that aims for "building trust," we re-story trustworthiness?

Changing frameworks and paradigms requires attention to the language used in the narratives. As such, metaphors matter. Metaphor is a way to use language to understand, experience, or express one kind of thing in terms of another. In their now-classic text, Lakoff and Johnson (2003) articulate how metaphors permeate our daily life (e.g., time is money; argument is war; love is blind, and so forth). These linguists emphasize that metaphors are particularly influential in describing emerging concepts. Metaphors do not merely describe, they *frame and* shape our understanding of concepts. Thus, a paradigm-shift in our understanding requires critical intentionality about the metaphors used.

As I go deeper in considering this reframe, I wonder about revising the "building metaphor" altogether. Instead, I'm considering metaphors such as "cultivating trustworthiness." Whilst perhaps initially useful in describing the phenomenon, *building* as a metaphor connotes a linear construction, finishing a product. In contrast, *cultivating* evokes images of planting, weeding, tending, nurturing a non-linear growth process.

This emerging reframe is important because it offers a different paradigm in terms of actions and solutions. This re-story is particularly relevant in consideration of myriad diverse identities and cultural contexts, with accompanying power differentials. Rather than definitive, dominant answers, this dialogical re-storying engenders expansive critical questions. This approach cultivates a process, rather than builds a case. Critical questions

include: How does centering trustworthiness rather than trust as the aim clarify accountability? Reframe roles, responsibilities, functions, and tasks? Redefine success? How could this emphasis on trustworthiness impact justice, liberation, equity, human rights, and wellbeing efforts—in all contexts? How might cultivation of trustworthiness change our views and approaches toward nurturing continuous, iterative growth, as contrasted with constructing a finished, linear product?

These questions are not merely rhetorical. The questions we ask determine the solutions we seek and the directions we pursue. Thus, these emerging key questions offer important guidance toward an expansive narrative that cultivates trustworthiness rather than a dominant paradigm that demands trust—in all aspects.

Further Considerations and Future Directions

The parameters of this article present several limitations in focus and scope. For example, although the proposed paradigm shift provides an important reframe to guide practice, this article does not provide a checklist of practice behaviors or action steps. Rather, using narrative and story-telling, it provides an explicit critical critique of the dominant narrative around trust versus trustworthiness and proposes a narrative more congruent with social work ethics. Instead of asserting definitive answers, I offer an initial consideration of critical questions to guide practice, whilst inviting further dialogue and development.

As such, the perspective of this article is both informed and limited. Significant future scholarship—including practice wisdom narratives—is needed to develop this area. Practice applications, professional implications, and specific actions that both challenge and implement the proposed ethical shift will inform future directions in ensuring that social work is a trustworthy profession.

The purpose of ethics is to guide in right decisions, directions, and actions. As eloquently expressed by Rory Truell, IFSW Secretary-General,

> Values and ethics are the glue that binds the [social work] profession…they are a guide that helps us through complex challenges. They…can be used as lens for understanding all the circumstances we encounter (Marson, 2023, p.19).

With this evocation, re-storying trustworthiness is an ethical imperative. Shifting from "trust" to "trustworthiness" as the aim is an ethical "re-right." I hope this article contributes by critically considering this topic and offering an initial reframing in the discussion. I hope it invites more study, dialogue, and practice of cultivating trustworthiness that nurtures a more just and joyful world for all.

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Anti-Racist Values in Portuguese Baccalaureate Social Work Education: A Content Analysis Study

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Erick da Luz Scherf, BA, MSW, PhD (Student)
The University of Alabama
edaluzscherf@crimson.ua.edu

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Abstract

Social work has been called upon to embrace anti-racist education, values, and ethics in teaching, research, and practice, however, formal assessments of the degree to which social work educational programs have adopted anti-racist values have been largely restricted to English-speaking countries. This study is a modest attempt to enlarge the literature on this topic by providing an assessment of anti-racist and diversity content in the undergraduate social work curriculum in Portugal, a Southern European country with a particular history of colorblind racism. It adopts a content analysis methodology, and it looks at course syllabi across several different social work programs. The main findings from the analysis of the formal curriculum tell us that Portuguese schools of social work lack an intentional and systematic approach to adopting anti-racist values and teaching about racial and ethnic diversity.

Keywords: Baccalaureate, social work, education, anti-racism, Portugal

For many years, the public perceptions of racism and related discrimination in Portugal have been guided by notions of colorblindness and rooted in lusotropicalist assumptions (Araújo, 2006; 2007; 2013; Valentim & Heleno, 2018). While modern colonialism in the early twentieth century was built on racist assumptions - i.e. the idea that colonized groups were in essence racially inferior - Portugal has for decades been regarded as a "benevolent" colonizer, therefore avoiding claims of racism (Araújo, 2013).

The historical portrait of Portugal as a good colonizer was drawn from Gilberto Freyre's idea of *lusotropicalismo*, the notion that the Portuguese were better colonizers than other Europeans and that race relations were remarkably peaceful and friendly under Portuguese rule (Araújo, 2013; Valentim & Heleno, 2018). These historical constructs, although often built on misguided assumptions, have managed to become social facts (Vale de Almeida, 2005), to the extent that ethnoracial discrimination has been institutionalized in many instances, not requiring any specific legislation targeting racialized and minoritized individuals but merely by failing to address existing hierarchies of power and privilege within Portuguese society (Araújo, 2016).

Araújo (2006; 2013) argues that the myth of Portuguese non-racism during and after colonial times contributes to the depoliticization of the debate on colonialism and racism, which, until today, fuel common narratives that portray Portugal as a country "at ease" with diversity (Araújo, 2013, p. 29). Therefore, there is a strong argument that the socio-political-historical background of colonialism and race relations largely influences the so-called management of difference in Portugal even in contemporary times.

This work is concerned with the degree to which these pervasive ideologies might have permeated social work education in Portugal over the years. This idea of a "natural" inclination toward tolerance and acceptance of difference in Portuguese society (Vala et al., 2002) – may it be differences in national origin, race, ethnicity, gender identity, or others – makes it hard to have public discussions on the meanings and ongoing impacts of racism, xenophobia, and discrimination.

In Portugal, there seems to be a widespread lack of recognition of racism as a social problem (Casquilho-Martins et al., 2022), even though a recent statement released by the United Nations Working Group of Experts on People of African Descent has confirmed the "prevalence of systemic racism and racially motivated violence and ill-treatment, racial profiling, abuse of authority, [and] frequent police brutality towards people of African descent" in Portuguese society (United Nations Office of the High Commissioner for Human Rights, 2021a, para. 8). The statement also mentions that the school curricula and textbooks in Portugal fail to properly address the country's history of colonial violence, enslavement, and involvement in the transatlantic slave trade (United Nations Office of the High Commissioner for Human Rights, 2021b).

Taking this context into consideration, this investigation is particularly concerned with the extent to which colorblind ideologies might still inform social work education in Portugal. The argument here is that a colorblind social work curriculum may contribute to these normative discourses and possibly to the reproduction of systemic oppression (Choi, 2008). Although highly understudied in Europe, in comparison to English-speaking countries especially in North America, these themes are essential to the education and training of social workers. Social workers are responsible for providing services to people from diverse backgrounds, and therefore, they must have a deep understanding of the complexities and nuances of various cultures, identities, and experiences. To effectively work with and advocate for clients or service users who are often racialized and minoritized, social workers must be equipped with the knowledge, skills, and values necessary to address issues related to racism, oppression, and discrimination. (Deepak et al., 2015; Olcoń et al., 2020).

If we look at the latest statement on Global Standards for Social Work Education and Training, "[…] knowledge of - human rights, social movements and their interconnectedness with class, gender and ethnic/race-related issues" is cited as a crucial component of social work educational programs (International Federation of Social Workers [IFSW], 2020, p. 12). Thus, teaching about anti-racism and diversity of lived experiences is a

crucial task for social work educators. This is why it is also important to revisit, time and again, how these issues are dealt with in the social work classroom.

Methods

This study adopted a content analysis methodology to assess the presence of certain themes relevant to the research objectives. Documents analyzed included: institutional landing pages, syllabi (*Planos de Estudos* in Portuguese), and curricular guidelines, that is, mostly materials easily accessible online. A literature review was also performed, which revealed only one other study addressing similar topics in social work education in Portugal (Sousa & Almeida, 2016). I have looked through the curricular plans and units of all active Bachelor of social work (BSW) programs across Portugal and have performed a word search for the terms race/ethnicity, and diversity, while also considering synonyms and comparable words/themes.

This type of research with the same methodology has been executed before in other contexts (e.g. Teasley & Archuleta, 2015), but not so much in Portugal. Looking at the curriculum is an important task because it is not merely a document - quite the contrary - it reflects broader power struggles over what is considered valid knowledge. It is also important to mention that, in general, curriculum, can often be separated into two categories: the explicit curriculum and the implicit curriculum (Herr et al., 2020). This article focuses only on the formal or explicit curriculum.

Literature Review: The History of Social Work Education and Practice in Portugal

The history of the social work profession in Portugal is very distinct and it accompanied the country's social and political transformations over the years. Carvalho (2010) analyzes the emergence of social work education and training in Portugal by reviewing textbooks, research articles, and her work

teaching in Portuguese higher education institutions. She divides the history of the profession into four eras: the first would be marked by the institutionalization of social work as a profession and field of training, which happened between the 1930s and 1940s (Carvalho, 2010); the second took place in the 1950s, 60s, and mid-70s, and refers to social changes and "professional discontinuities" which took place across these three decades (Carvalho, 2010); the third one spans a period that encompasses the April Revolution of 1974 (popularly known as the Carnation Revolution), until the 1990s, and is marked by a reaffirmation of the profession (Carvalho, 2010); the fourth epoch is situated between the 1990s and 2004, and is characterized by a strong consolidation of the social work profession in the country (Carvalho, 2010). Ultimately, according to her, the contemporary portrait of the profession is defined, among other things, by the period of education reform following the Bologna process, neoliberalism, and the global financial crisis, as well as ongoing struggles for recognition and professionalization (Carvalho, 2010).

Ferreira and Pena (2014) also provide a historical overview of social work education and practice in Portugal. According to them, the history of social work education in Portugal started with the creation of the first Portuguese School of Social Work, the 'Lisbon Superior Institute of Social Work', in 1935, followed by the creation of the Coimbra Social School in 1937 (*Escola Normal Social de Coimbra*). At its birth, social work education in the country was oriented toward social intervention of different kinds (Ferreira & Pena, 2014). Carvalho (2010) also notes that social work practice in Portugal during its 'first era', as aforementioned, was strongly marked by ideals of social control, especially over poor and marginalized populations in favor of dominant political ideologies.

Nonetheless, over the years, both social work education and practice in Portugal have transformed considerably to respond to challenges brought about by European integration, globalization, and other factors. For instance, Carvalho and Pinto (2015) offer a historical overview of the social work profession in Portugal, while highlighting the current challenges it faces as well. They argue that, even though social work education and

practice in Portugal emerged in a dictatorial context (under the Estado Novo), social work knew how to reinvent itself and face the oppressive regime by integrating democratic principles and values associated with civic, political and social rights (Carvalho & Pinto, 2015). It also transformed its nature from voluntarism/assistentialism to professionalization built on theoretical and practical evidence, forming a journey of autonomy and scientificization (Carvalho & Pinto, 2015).

It is important to highlight that the emergence and the institutionalization of the social work profession in Portugal were characterized by ideas of racial superiority and repressive morality (Carvalho, 2010; Carvalho & Pinto, 2015). It was also dominated by women of the bourgeois classes and highly influenced by reformist ideas linked to the national education political project, which carried the motto "God, nation, and family" (Deus, pátria e família in Portuguese) (Carvalho & Pinto, 2015).

In the years following democratization, especially in the early and mid-1970s, Portuguese social work practice and education took a turn toward what Santos and Martins (2016) called a critical trend(s). From 1973 onwards, Portuguese social work grew closer to the class struggle and union movements, also advocating for the end of the salazarista dictatorship (Santos & Martins, 2016). It started to question the supposed neutrality of social work and its positivist nature, aiming to conceive the profession in light of current developments (at the time) of critical thinking, either through the dialogue between Christianity and Marxism, or through the pedagogy of Paulo Freire (Santos & Martins, 2016). Also noteworthy, during this period, was the great influence of the Reconceptualization movement within Latin American social work (Santos & Martins, 2016). Between the 1980s and early 2000s, several other important transformations took place regarding social work education in Portugal, especially after the country joined the former European Economic Community in 1986 and after adhering to the Bologna Declaration in 1999 (Santos & Martins, 2016).

Santos and Martins (2016) have also looked at curriculum plans or units (Planos de Estudo) of different schools of social work in Portugal, and they also conducted interviews with professors and course coordinators/direc-

tors, to investigate the role of critical thought in social work education, especially related to the theoretical traditions of Ccritical and radical social work practice (Santos & Martins, 2016). Their findings indicate that within those frameworks, different traditions are discussed during the education of social workers in Portugal: from feminist theories/interventions to critical/dialectical social work and anti-discriminatory, anti-oppressive, and empowerment practices (Santos & Martins, 2016).

However, in their work, it is not very clear how schools of social work in Portugal implement antiracist pedagogies or diversity-related content. Furthermore, their research findings (Santos & Martins, 2016), suggest that there is an ongoing struggle between two forces within social work education in Portugal: one that is oriented toward homogeneity/order/regulation within the profession, and another one that privileges critical traditions, including anti-discriminatory and anti-oppressive frameworks.

Sousa and Almeida (2016), on the other hand, decided to look specifically at the place of diversity and culturally sensitive practices in social work education in Europe, with a focus on Portugal and Portuguese universities and institutes. Their article is based on research that aimed at finding out if there are mandatory curricular units within social work programs that explicitly address culturally sensitive social work, cultural competencies, and diversity content (Sousa & Almeida, 2016). They performed an online survey and a document analysis of the curricula of all Portuguese courses in social work (Sousa & Almeida, 2016). According to them, social work courses and programs in Portugal have different curriculum programs, as the country lacks National Standards of Education concerning social work education (Sousa & Almeida, 2016). This is why looking at different curricula and syllabi is an important task, given that social work education in Portugal does not have a common curriculum based on national educational policy or accreditation standards (Sousa & Almeida, 2016). Their findings suggest that "in general, from the main outcome of the study, it may be concluded that the courses of social work do not have a curriculum offer that addresses diversity/cultural sensitivity/cultural competence as compulsory" (Sousa & Almeida, 2016, p. 14). Moreover, they argue that "the absence of well-deve-

loped cultural competences can lead to a color-blind view of reality and to a certain cultural daltonism" (Sousa & Almeida, 2016, p. 14). Their findings have contributed significantly to my choice of pursuing this theme, in hopes of challenging colorblind ideologies in social work education in Europe in general and in Portugal more specifically.

Carvalho et al. (2019) explore recent shifts in social work education in Portugal, from what they characterize as 'exclusivity' to a 'massification' process. They employ a critical understanding of higher education and argue that although education is a right, "it has become a commodity as a result of the Bologna process" (Carvalho et al., 2019, p. 690). Many challenges have arisen in recent years according to them, including a "dispersion of an educational project theoretically, methodologically, and ethically consistent in our country, defined by social workers and trained by them (in schools) to a mass model where any teacher from these universities and institutes could also teach social work" (Carvalho et al., 2019, p. 702). They also blame the reduction of years required to graduate with a social work degree and the lack of teaching guidelines for the scientific areas of social work and related fields (Carvalho et al., 2019) for the reduction in quality and the massification of social work education in the country, among other things.

Sousa and Almeida (2021) reiterate the problem regarding a lack of standards and guidelines for accreditation of social work education in Portugal and argue that "standards in social work education should set out what students need to learn to do, what they need to be able to understand, and the competences they must have when they complete their training to be prepared for the labor market" (Sousa and Almeida, 2021, p. 202). Menezes (2021) also mentions the role of academic training in social work in Portugal as a structuring and identity element; she argues that initial training in social work should encompass reflective teaching, based on the consolidation and internalization of new forms of social work research, practice, and education (Menezes, 2021).

Although the majority of the studies on this topic are from English-speaking countries, Sousa and Almeida (2016) shed light on the place of diversity and culturally sensitive practices in social work education in Europe,

specifically in Portugal. Their research findings suggest that the lack of compulsory curriculum units that address diversity/cultural sensitivity/cultural competence lead to a color-blind view of reality and cultural daltonism. The absence of well-developed cultural competencies highlights the need for standards and guidelines for the accreditation of social work education in Portugal. As Menezes (2021) argues, academic training in social work should encompass reflective teaching based on new forms of social work research, practice, and education. This study builds on the work of Sousa and Almeida (2016) and expands the analysis of anti-racist values in social work education in Portugal.

Content Analysis of Portuguese BSW Curricula: Results and Discussion

Because social work is a profession guided by principles of social justice, the social work curriculum needs to reflect the lived experiences of diverse populations, especially those who have been historically racialized, minoritized, and marginalized. To interrogate the role of the curriculum in (re)producing unequal power relations, Professor Michael W. Apple poses a series of questions that might illustrate what being critical about the curriculum may look like:

> Whose knowledge is this? How did it become 'official'? What is the relationship between this knowledge and how it is organized and taught and who has cultural, social and economic capital in this society? Who benefits from these definitions of legitimate knowledge and who does not? What are the overt and hidden effects of educational reforms on real people and real communities? What can we do as critical educators and activists to challenge existing educational and social inequalities and to create curricula and teaching that are more socially just? (Apple, 2018, p. 2).

Movements toward contesting the curriculum in higher education have taken place in the United States, United Kingdom, and France since the

1960s (Murphy, 2021). Recent mobilizations such as the *Why is My Curriculum White* movement in England have gained notoriety as they highlight a lack of awareness that the curriculum often reflects 'White ideas' written by 'White authors', as a result of colonialism, epistemic violence, and the naturalization of whiteness in educational settings (Peters, 2015).

However, many White educators are still resistant to recognizing the harmful, ongoing legacies of racism and colonialism in the curriculum of different higher education institutions (Picower, 2009), especially in previous white-settler colonialist societies. In Portugal, this historical amnesia has been frequently reproduced in education, politics, and society. Marta Araújo (2013) argues that education, most notably in the Portuguese history curriculum and textbooks, imposes or reinforces an anachronical image of a homogeneous nation, marked by a White, Christian, national identity while downplaying colonialism and inequalities tied to the race/power binary (Araújo, 2013).

The result is an education that is frequently disconnected from the mental and material aspects of colonialism, institutional racism, and related discrimination (Araújo, 2013; 2018). If left unchallenged, the reproduction of this mentality in social work education can have negative implications for social work students (Abrams et al., 2021), especially minoritized ones, and for the present and future of the social work profession. Teaching about race, ethnicity, and diversity is a crucial task in the larger strategy which is to decolonize and diversify the curriculum (Housee, 2021). Efforts are needed to address discrimination and personal biases in social work education programs, especially in the Portuguese context.

In 2020, the Portuguese National Council of Education (Conselho Nacional de Educação) released a recommendation concerning the role of anti-racist education in the country. The document mentions the persistence of institutional blindness to racism and discrimination, and a failed attempt of Portuguese society to implement a "post-racial strategy," as if not talking about race/ethnicity will make racism and related discrimination simply go away (Menezes et al., 2020). Considering this background of colorblind assumptions in education, politics, and society, the Council

suggested, among other things, the inclusion of anti-racist, anti-discriminatory, and diversity content in all levels of formal education in Portugal (Menezes et al., 2020). Despite these provisions and recommendations, is it not completely clear how schools of social work across Portugal incorporate (or not) these themes into the formal curriculum, which is why this investigation was developed.

After going through every curricular unit of every syllabus available online, a few patterns could be identified. The first one is that the content in the formal curriculum varies greatly among higher education institutions in Portugal. As mentioned previously, social work education in Portugal does not follow nationally established guidelines, which means that universities responsible for deciding what is going into the formal curriculum and what is not. Therefore, one BSW program can look very different from another in terms of core courses and competencies. Secondly, it was possible to identify that the majority of BSW programs integrate at least some content about diversity, especially cultural diversity, in the core curriculum. Thirdly, while some syllabi integrated topics related to discrimination, racial and ethnic discrimination appeared less frequently in comparison to other topics. In Table 1, the extended results of the curricular analysis are presented.

Higher Education Institution	Race/ethnicity, racism, and related discrimination	Diversity (social and cultural), and/or intersectionality	Migration-related content	"Transversal competencies" (these modules are available to all majors)
ISCTE-IUL, University Institute of Lisbon	No	Yes **02846 - Laboratory in Social Work Settings and Fields**, 2. Children/young people, Seniors, Gender, Dependencies,	Yes **L5133 - Sociology of International Migrations**	Yes **Diversity in the workplace** (1 ECTS) **Intro. to gender equality and diversity** (1 ECTS)

		Exclusion processes, Interculturality **L6102 - Social Classes and Stratification** 1.7. Classes, gender, ethnicity – intersectionality *Mandatory*	*Optional*	*Optional*
University of Lisbon (ULisboa)	Yes **9238209.Anthropology** Unit 3.1. Race, Ethnicity, and Nation; Unit 3.2. Ethnic relations: majorities and minorities. **9238310. Contemporary Theories of Social Work** Unit 3.2.1 Feminism, anti-racism, anti-oppression, and social activism. **9238502. Models of Intervention in Social Work**	Yes **9238209.Anthropology** **9238111. General sociology.** Unit II, Gender and Sexuality. **9238310. Contemporary Theories of Social Work** Unit 3.2.1 Feminism, anti-racism, anti-oppression, and social activism. **9238502. Models of Intervention in Social Work** 2.6 Empowerment and advocacy; 2.7 Critical model, anti-oppression and anti-discriminatory practice	Yes **9238209.Anthropology** **9238202. Applied Sociology** **9238308. Demography**	Not applicable

	Mandatory	**9238604. Social Work and Ageing** *Mandatory* **9238115. Social Work in the Areas of Disability and Mental Health** *Optional*	*Mandatory*	
University of Coimbra	No	Yes **01010213. Theoretical Foundations of Social Work** Mentions of multiculturalism, advocacy and empowerment, intercultural mediation, and reflexivity in social work practice **01010197. Sociology of Development** 2. Cultural diversity and multiculturalism **01010298. Educational Gerontology and Active Aging** **01741796. Rehabilitation in Special Populations**	No	Not applicable

		Disability studies *Mandatory*		
Universidade Lusófona	No	Yes **ULHT119-16426. Intervention in the Area of Diversity and Interculturality** **ULHT119-22372. Intervention in Social Gerontology** *Optional*	No	Not applicable
University of Açores	No	Yes **0102047. Introduction to Sociology** 4.2. Culture and Society **0106053. Vocational Social Work Contexts** Social work with diverse populations *Mandatory* --- **0102012. Sociology of Culture** *Optional*	No	Not applicable

Catholic University of Portugal – Lisbon (Universidade Catolica de Portugal)[15]	Yes **Sociology I** 2.4. Race and ethnicity **Cultural Anthropology** 2.3. Race and ethnicity **Social work: paradigmatic fields and theories** 3.5. Critical theories: radical and anti-oppressive Social Work practice *Mandatory*	Yes **Sociology I** 2.1. Culture and Society 2.5. Sex and gender **Cultural Anthropology** 2.2. Sexuality, identity and culture 3.1. Multiculturalism, interculturalism and acculturation **Social Work and Human Rights** 5.3.Critical perspective, guarantee of human rights, and respect for cultural diversity *Mandatory*	Yes **Seminar: Social Work Laboratory** 3.2. Social Work, migration processes, and refugees *Mandatory*	Not applicable
Universidade Lusíada, Lisboa	Yes **L4401. Anthropology of complex societies**	Yes **L4401. Anthropology of complex societies** Cultural diversity, sex, and gender	Yes **L4405. Seminar: Introduction to Social Problems**	Not applicable

[15] At the time of consultation, information about the BSW program at this HEI was only available regarding the first year of courses, information about years two and three was missing from their website. See: https://fch.lisboa.ucp.pt/pt-pt/licenciaturas/programas/licenciatura-em-servico-social/plano-curricular

	Racism, ethnicity, and identity **L4405. Seminar: Introduction to Social Problems** 2.7 - Racism, prejudice, and ethnic and religious discrimination *Mandatory*	**L4403. Globalization and Inequalities** **L4405. Seminar: Introduction to Social Problems** 2.6 - Criminality, discrimination, and gender and sexual violence **L4407. Human development contexts** "6. People with special needs and developmental problems" **L4409. Social Work and Society** 3. Human Rights, Cultural Diversity and Local Identities: dilemmas and challenges of Social Work *Mandatory*	2.1 - Demographic social problems: population and migrations *Mandatory*	
University of Trás-os-Montes and Alto Douro (UTAD)	Yes **12622. Introduction to Sociology** 2.2 Ethnicity **12640. Social Psychology**	Yes **12623. Introduction to Social Sciences** Module 6 - Analysis of social and cultural reality **12613. Social, family, and**	Yes **12615. Political economy of globalization** 1. […] Migratory movements, flexible work, new forms of poverty, discrimination	Not applicable

	IX - Stereotypes, prejudice, and discrimination *Mandatory* **12630. Migrations and interculturality** 4. Migration, ethnicity and racism 4.3. From the lusotropicalist myth to post-colonial racism in Portuguese society 4.4. Biological racism, new racism, and institutional racism **12643. Theories of social intervention** 4.1 Anti-oppressive practice 4.2 Radical Social Work *Optional*	**generational dynamics** 6. Family and gender relations in contemporary Portugal **12638. Developmental problems** Cognitive diversity **12609. Culture, and society: anthropological perspectives** **12606. Citizenship, social exclusions, and empowerment** *Mandatory* **12630. Migrations and interculturality** *Optional*	and social exclusion. *Mandatory* **12630. Migrations and interculturality** *Optional*	
Higher Institute of Social Work of Porto (ISSSP)[16]	No	No	Yes	Not applicable

[16] At the time of consultation, information about the BSW program at this HEI was only available regarding the first and second years of courses, information about year three was missing from their website. See: https://www.sigarra-isssp.pt/isssp/planos_estudos_geral.formview?p_Pe=630

			SS2210209. Societal Phenomena II 1.2.3. The social and cultural integration of migrants in host societies *Mandatory*	
Polytechnic Institute of Leiria[17]	No	Yes **9238507 Social and Cultural Anthropology** **9238520 Problems of Contemporary Society and Culture** **9238528 Multiculturalism and Intercultural Education** *Mandatory*	No	Not applicable
Polytechnic Institute of Portalegre	Yes **Social Work, Inequalities, and Social Exclusion** Prejudice, stereotype, discrimination, stigma.	Yes **General Sociology** 6. Gender, sexuality and gender inequalities **Social and Cultural Anthropology**	Yes **Vulnerable Populations** 5. Immigrants and Ethnic Communities. 5.2. Immigrant communities in Portugal:	Not applicable

[17] Information about specific contents in the syllabi was missing from this HEI's website; only a list of courses was available. See: https://arquivo.pt/noFrame/replay/20221125215619/ and https://www.ipleiria.pt/curso/licenciatura-em-servico-social/

	The importance of anti-oppressive practice and critical reflection on the practice of social work. **Vulnerable Populations** 5.3. The Roma ethnicity in Portugal: characterization, main problems and possible solutions *Mandatory*	3.2. Cultural identities, multiculturalism and cultural relativism **Rehabilitation, Disability, and Mental Health** *Mandatory*	characterizatio n and perspectives of social inclusion *Mandatory*	
Polytechnic Institute of Beja	Yes / But partially only **923823 - Theory of Social Work II** 7. The perspective of Anti-oppressive and Anti-discriminatory intervention	Yes **923802 - Contemporary Social Problems** 5. Some social problems and needs associated with specific groups: 5.3. People belonging to ethnic-cultural minorities **923810 - Social and Cultural Anthropology** 4. Multi-interculturalism 2. Sociocultural unity and diversity in Portugal: ecology and society	Yes **923802 - Contemporary Social Problems** 5. Some social problems and needs associated with specific groups: 5.2. Migrants *Mandatory* **923830 - Option 2 – Social Work Intervention - b) Intercultural Mediation**	Not applicable

	Mandatory	**923816 – Sociology of the Family** 4. The family in contemporary society: diversity of family forms *Mandatory* **923830 - Option 2 – Social Work Intervention -b) Intercultural Mediation** *Optional*	*Optional*	
Polytechnic Institute of Viseu[18]	No	Yes **3186501208 Sociocultural Anthropology** Learning goal: "to reflect critically on the problem of unity and human diversity" **3186502116 Sociology of the Family** III.1 Plurality of forms of the family **3186502117 Intergenerational Social Work** *Mandatory*	No	Not applicable

[18] Information about several Curricular Units from the BSW program at this institution was missing. See: https://www1.estgl.ipv.pt/fichas-ects-de-ss

Polytechnic Institute of Castelo Branco[19]	Information not available online	Information not available online	Information not available online	Information not available online
Miguel Torga Institute of Higher Education[20]	Information not available online	Information not available online	Information not available online	Information not available online

Table 1: Results from the review of curricular units and course syllabi of Portuguese BSW programs. Source: Elaborated by the author based on online information available at HEIs' institutional websites.

The above findings from the analysis of the formal curriculum alone are preoccupying because race, ethnicity, and/or ethnic and racial discrimination appear in the curricular units at a much lower rate than the other topics. With that said, while Portuguese BSW programs perform relatively well in integrating diversity and migration-related content in the core curriculum, race/ethnicity, racism, xenophobia, and related discrimination rank the lowest among the topics selected for this study. Critical Race Theory (CRT) would tell us that addressing systemic racism and related systems of oppression must be a foundational component of social work education (Williams, 2022). CRT would also compel "[…] us to address the complexities of systemic racism as they relate to social justice issues in the field of social work" (Williams, 2022, p. 2).

Considering Portugal's history of institutionalized racism and colorblind attitudes, an absence of these themes in the formal social work curriculum might lead to an unintended colorblind view of reality. From the viewpoint of CRT and anti-racist pedagogy, Portuguese schools of social work could benefit from incorporating these themes into the curriculum in a

[19] This HEI did not disclose the contents of the Curricular Units on its website: See: https://www.ipcb.pt/esecb/ensino/licenciatura-em-servico-social

[20] This HEI did not disclose the contents of the Curricular Units on its website: See: https://ismt.pt/pt/servico-social#study-plan

more objective manner, so that social work educators can engage in meaningful discussions about the ongoing implications of ethnoracism, racial injustice, and so on. A quantitative summary of the curricular analysis is displayed in Table 2.

	Race/ethnicity, racism, xenophobia, and related discrimination	Diversity (social and cultural), and/or intersectionality	Migration-related content
Number of BSW programs with explicit mentions in the formal curriculum (mandatory courses only)	**5** (≈ 38%)	**13** (100%)	**7** (≈ 54%)
Total number of programs analyzed: 13 (two programs were left out of the count for not having information available online)			

Table 2: Quantitative content analysis of BSW programs in Portugal concerning the selected themes. Source: Elaborated by the author.

On the other hand, in terms of the diversity content, culturally sensitive practice and cultural humility emphasize the importance of acknowledging and respecting diverse cultures, values, and experiences in social work education and practice (Gottlieb, 2021). The finding that the integration of migration-related content is relatively strong in Portuguese BSW programs aligns with these frameworks, as migration is a significant aspect of cultural diversity. However, in terms of socio-cultural diversity, diversity content is usually delivered through either sociology or anthropology courses, which means that it is not clear how this content is translated to cultural competencies in social work practice, therefore, there might be a need to further develop cultural sensitivity within the curriculum, so that social workers can work effectively with diverse populations.

Especially concerning anti-racist values, if one cannot identify these topics throughout the formal curriculum, it is hard to objectively evaluate their presence, or absence for that matter. Ethnoracial issues and diversity content are addressed in fundamentally different ways across various BSW programs in Portugal. While at some HEIs, they occupy a more privileged

space in the curriculum, they appear in less frequency at others. The pedagogical tools and methodologies chosen to introduce and debate these themes also seem to be fundamentally different across the HEIs represented in this study. An explicit commitment to anti-racist education is necessary to challenge racism and discrimination and to promote social justice through social work education and practice. Therefore, these findings suggest that many BSW programs in Portugal are lagging behind. I would thus encourage Portuguese schools of social work to adopt a bolder and more consistent approach to diversity and racial justice in social work education, providing students with the necessary tools to navigate and transform an unequal and racialized society.

Concluding remarks

The main goal of this study was to assess the presence of anti-racist and diversity values in undergraduate social work education in Portugal. After analyzing the formal curriculum of BSW programs in Portugal using content and document analysis techniques, it is unequivocal that the curriculum of first-cycle social work programs at the majority of higher education institutions lacks a clear and systematic strategy to address the themes of anti-racism, anti-discrimination, and culturally sensitive practice.

While cultural difference is debated in pretty much every BSW program across the country, anti-racist values are not always expressly mentioned. It is important to highlight that, in Portuguese society, there is widespread social avoidance when it comes to addressing racism in public spaces, which is reproduced at some level in the social work classroom. Portuguese politicians refuse to acknowledge the existence of minority groups in the country (ACFC [Advisory Committee on the Framework Convention for the Protection of National Minorities], 2019), and Portuguese legislation prohibits the production of data that reveals a person's racial or ethnic identity. While in other countries such as the United States, where teaching about racial and ethnic diversity has been a mandate of social work education since the 1980s, these issues do not seem to have occupied a privileged

space in the history of social work education in Portugal. Therefore, while the Portuguese social work curriculum is not entirely colorblind, some BSW programs might be missing key competencies related to anti-racist and anti-discriminatory social work practice in connection to a subjective frequency of when and how these themes are discussed.

To foster anti-racist values in social work education, Portuguese schools of social work could aim for a more consistent and comprehensive approach to addressing diversity and ethnoracial issues across the curriculum. This can be done in several different ways. Good examples should be amplified through knowledge exchange and cooperation between different social work programs across the country. Steps could be taken to ensure that: (i) there is a greater emphasis on diversity coursework, and (ii) there is a serious commitment to anti-racist education in BSW programs in Portugal. Other aspects could involve providing social work educators with specialized programs and training in the area of Diversity, Equity, and Inclusion (DE&I), as well as with competencies necessary to address systemic racism and discrimination.

One of the major limitations of this study is that it only looked at the formal curriculum, whereas the hidden or implicit curriculum also carries important weight in higher education. Therefore, for future research, social work researchers and educators could consider interrogating classroom practices and policies with the use of ethnographic methods, and/or in-depth interviews with both social work educators and students in Portugal, to capture the nuances and complexities that are not necessarily represented in the formal documents that inform teaching in social work.

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Involuntary Hospitalization: Does Social Work Education Prepare for Competency? A Systematic Review

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Jennifer L. Robertson
Tulane University, School of Social Work
jrobertson@tulane.edu

Candice C. Beasley
Tulane University, School of Social Work
cbeasley@tulane.edu

Robertson, J. & Beasley, C. (2024). Involuntary Hospitalization: Does Social Work Education Prepare for Competency? A Systematic Review. *International Journal of Social Work Values and Ethics*, 21(2), 115-142. https://doi.org/10.55521/10-021-209

Abstract

The aim of this systematic review is to investigate competencies of social workers in managing psychiatric emergencies that potentially result in involuntary hospitalization. Specifically, is there an accessible body of research indicating that social work education prepares for competency as it relates to involuntary hospitalization? Under federal law, each state has the power to enact its own laws relating to involuntary hospitalization, making it difficult for the Council on Social Work Education to incorporate the standardization of psychiatric emergent processes within the Educational Policy and Accreditation Standards. However, if tenets of involuntary hospitalization are not incorporated into curricula of social work practice degrees, how may the profession ensure future social workers are prepared to support, advocate, and function within the scope of their practice and assigned roles/responsibilities with respect to involuntary hospitalization? A systematic review of literature from October 2004 to October 2021 across the disciplines of social work yielded 461 articles. Using the

Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA), five articles met the requirements for inclusion regarding social work education and competency in knowledge on involuntary hospitalization. Findings conclude that there is minimal evidence of any standardized training and education within social work leading to competency related to involuntary hospitalization.

Keywords: Social work, involuntary hospitalization, competency, education

Literature Review

Involuntary hospitalization for mental illness can elicit thoughts of straitjackets, padded rooms, and asylums popularized by movies and television; however, these images are no longer the reality of mental health treatment. The progression of services and policies over the past hundred years is a testament to research and growth in the mental health professional community. Involuntary hospitalizations date back to 13th century law; even then there was an acknowledgement by community leaders that some people needed to be cared for more than others (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019). The policies and laws on involuntary hospitalization come from the English common law of *parens patriae*, a term defined as a government's responsibility to protect the people within its society (Appelbaum, 1996; Brooks, 2007; Garakani et al., 2014).

The Civil Rights of Institutionalized Persons Act of 1980 and the Americans with Disabilities Act encouraged states to move away from inpatient care to community-based care, while utilizing the least restrictive care possible (SAMHSA, 2019). First, in 1987, later revised in 2000, the American Psychiatric Association helped create guidelines for people with grave disability due to mental illness who were not an imminent threat to themselves or others, allowing them outpatient commitment in lieu of involuntary hospitalization (Anfang & Appelbaum, 2006). The Mental Health Civil Commitment Act of 2002, revised to the District of Columbia Mental Health Civil Commitment Modernization Act of 2004, set forth an updated policy on involuntary hospitalizations while outlining laws for emergency observation

detention, and providing representation by counsel for patients. This law provided checks and balances for involuntary hospitalization and protections for mental health, medical, and law enforcement professionals acting in good faith (District of Columbia Mental Health Civil Commitment Modernization Act, 2004).

In 2020, approximately 21% of American adults struggled with some form of mental illness, with about 5% of American adults struggling with a severe form of mental illness that created significant disruptions in their ability to function in daily life (National Institute of Mental Health [NIMH], 2022). About 40% of those with severe mental illness are not receiving treatment either by choice, lack of access to services, or lack of funding (Hedman et al., 2016; NIMH, 2022). Hedman et al. (2016) found that over the 50 United States there are eight different potential reasons for involuntary hospitalization (danger to self, danger to others, mentally ill, danger to self due to mental illness, danger to others due to mental illness, recently attempted suicide, gravely disabled, and unable to meet basic needs), with each state incorporating between two and four of these reasons into their state statutes. The amount of time a person is hospitalized varies from 23 hours to an unspecified amount of time, with up to 22 different types of community members and professionals who can initiate the hospitalization across states (Hedman et al., 2016). Additionally, states vary in their definition of "mental illness" (Christy et al., 2007) and even how they measure the length of time a person is inpatient, as some states do not count weekends and holidays (Garakani et al., 2014).

Ambiguity between state laws makes it difficult for those that are involuntarily hospitalized to have their rights protected. In many states, health care providers (including social workers) or peace officers need only have a "reasonable belief" that someone is in a mental health crisis, a standard much lower than the burden of proof for "probable cause" used in criminal justice scenarios (Gregoire et al., 2021). This is true even though the limitations on civil liberties caused by an involuntary hospitalization are synonymous to what happens when one is in the criminal justice system; yet unlike in criminal court scenarios, involuntary hospitalization can initially

occur without a court hearing (Hedman et al., 2016; SAMHSA, 2019). Furthermore, mental health, unlike medical health, can be legally mandated (Clark et al., 2005). Due to these factors, professional ethics must be consistently applied to ensure the protection of potential patients' civil liberties.

SAMHSA (2019) brings to light four main ethical areas of consideration for involuntary hospitalization: respect for autonomy, non-maleficence, beneficence, and justice. One crucial notation made by the literature is the patients' feelings of coercion when receiving involuntary treatment; patients feel as if they must accept treatment or continue to have limited rights even if the treatment is not what they want (Guzmán-Parra et al., 2019; Jones et al., 2021; Vuckovich & Artinian, 2005; Zervakis et al., 2007). Autonomy is difficult to maintain when a person has either real or perceived lack of freedom and choice. Considerations of non-maleficence and beneficence can be viewed together as avoiding harm and risk-benefit weighing. Xu et al. (2018) and Borecky et al. (2019) identified that both the act of being hospitalized and the event of forced treatment cause high associations of stigma-related stress and post-traumatic stress. These two studies also noted increased suicidality during and after treatment due to the stressors of involuntary hospitalization (Xu et al., 2018; Borecky et al., 2019). Despite the aforementioned findings, professional understanding related to the long term effects of involuntary hospitalization is limited (Zervakis et al., 2007), making it difficult to fully understand if the role of the mental health professional is authentically acting in the best interest of patients.

Review of the literature also reveals obstacles within research related to involuntary hospitalization, including lack of accurate comparison groups, primarily short term outcomes reported, and having clinical staff administer the research tools in lieu of researchers. Comparing involuntary patients to voluntary patients, one to one, is flawed as there are too many fundamental differences in the groups (Clark et al., 2005). As the research shifts to the evaluation of healthcare providers, concerning themes related to competency develop.

Throughout the literature, several authors have noted healthcare providers using non-medical reasons and non-statute driven reasons (reasons

with no legal substantiation) for involuntarily hospitalizing people; both lack of knowledge on laws and lack of training availability in residency and internship for all types of medical and mental health professionals appear to perpetuate this issue (Dolan & Fine, 2011; Holder et al., 2018; Hom et al., 2020; Hotzy et al., 2019; Kaufman & Way, 2010; Lincoln, 2006; Sattar et al., 2006; Shdaimah & O'Reilly, 2016). Spanning the years since 2004, authors have called to action for more training (Byatt et al., 2006; Garakani et al., 2014; Parker et al., 2006; Sisler et al., 2020, Zervakis et al., 2007) and more literature on decision making (Brennaman, 2015; Clark et al., 2005; Hotzy et al., 2019; Vuckovich & Artinian, 2005). Yet it is unclear whether foundational involuntary hospitalization training (within educational, agency, and organizational settings) and current research on decision-making autonomy in mental health and wellness are occurring within the profession of social work.

Since the enactment of District of Columbia Mental Health Civil Commitment Modernization Act (2004), there have been no new federal updates related to involuntary hospitalization for people with mental illness. The authors seek to understand, through the examination of peer-reviewed research, whether social work research in the United States of America (USA) is mindful of social work practice competency on a seventeen-year-old policy that impacts the freedoms of self-determination and autonomy. Further, practice experience advises that in most westernized constructs, it is expected by agencies, organizations, and medical institutions that social workers competently engage in the involuntary hospitalization process. Therefore, it is imperative to determine whether the profession can competently meet this expectation. The authors engaged in this determination by attempting to locate an accessible body of literature that investigates the competencies of social workers in managing psychiatric emergencies that potentially result in involuntary hospitalization. Specifically, is there an accessible body of research indicating that social work education prepares for foundational competency as it relates to the involuntary hospitalization process?

Methods

A systematic review was completed using the Preferred Reporting Items for Systematic Reviews and Meta-Analysis, also referred to as the PRISMA Flow Diagram (Page et al., 2021). The scope of this seventeen-year review was to locate a concise body of literature that identifies whether social work education prepares social work professionals for foundational competency related to involuntary hospitalization with dates including the most recent revision of District of Columbia Mental Health Civil Commitment Modernization Act in October of 2004 to the date of research commencement in October 2021. Due to the sensitive nature of the involuntary hospitalization process, this systematic review solely utilized published peer-reviewed literature. Critical appraisal of articles was performed through a two-reviewer process with each author independently appraising each article for inclusionary and exclusionary criteria. For articles that were unable to be retrieved, both authors made all reasonable attempts to manually retrieve said articles, however due to a copyright embargo, three articles were unable to be retrieved and therefore were unable to be included in the study. Each author read all retrieved articles, rating each as included or excluded with reason. Any discrepancies were discussed, and a consensus achieved.

PRISMA Flow Diagram Steps

The authors completed the following steps to gather generalized, operational, and current literature regarding guidance in critically identifying whether social workers possess foundational competency regarding the process of involuntary hospitalization. To locate this body of literature, 20 healthcare and social science databases were extracted from EBSCOhost Research Platform: SocINDEX with Full Text, Academic Search Complete, Alt HealthWatch, APA PsycArticles, APA PsycInfo, Criminal Justice Abstracts with Full Text, ERIC, Family Studies Abstracts, Health Source: Nursing/Academic Edition, Legal Source, LGBTQ+ Source, MEDLINE, Military & Government Collection, Professional Development Collection, Psychology and Behavioral Sciences Collection, Race Relations Abstracts, Social Work

Abstracts, Urban Studies Abstracts, Violence & Abuse Abstracts, Women's Studies International, and CINAHL Complete. These databases were searched for peer-reviewed publications from October 2004 through October 2021 and screened through the use of Excel. The keywords utilized were: "social work," "mental health law," "mental health professional," "healthcare professional," "education," "knowledge," "practice," "competency," "involuntary hospitalization" and "council on social work education" (See Appendix 1). Inclusionary criteria entailed that articles must have been: published within the seventeen-year time span, peer-reviewed, written in the English language, and available in full text. The articles also were to be specific to involuntary hospitalization (conducted within the USA) and identify involuntary hospitalization efforts that reflected social work competence. Exclusionary criteria included: articles and journals that were not peer-reviewed, articles published prior to the last seventeen years, articles with research not conducted within the USA (as countries outside of the USA are not subject to District of Columbia Mental Health Civil Commitment Modernization Act of 2004), articles that were not peer-reviewed, articles that were not in the English language, and articles that did not include mention of "social work," "involuntary hospitalization," "competency," and "education."

Results

Through the use of the 2020 PRISMA Flow Diagram (Page et al., 2021), records identified through the keyword search yielded 461 possible articles; 136 duplicate articles were removed, and 325 full-text articles were assessed for eligibility. Authors were unable to retrieve three articles due to a copyright embargo. Out of the 322 remaining articles, 317 articles failed to meet the inclusionary standards: 201 articles described research that was conducted outside of the USA, 39 articles were not peer-reviewed research (i.e., first person narratives, instructional guides, and book reviews), and 77 articles did not meet the Boolean Search Terms for the aforementioned

inclusionary criteria. Therefore, five articles (n = 5) (see Figure 1) met all aspects of the inclusionary criteria (see Figure 2).

Inclusionary Articles	Peer Reviewed	Published 10/2004-10/2021	Conducted in USA	Social Work	Compentency	Involuntary Hospitalization	Education
Brodwin, 2014	x	x	x	x	x	x	x
Holder et al., 2018	x	x	x	x	x	x	x
Hom et al., 2020	x	x	x	x	x	x	x
Reder & Quan, 2004	x	x	x	x	x	x	x
Shdaimah & O'Reilly, 2016	x	x	x	x	x	x	x

Table 3: Systematic Review Results

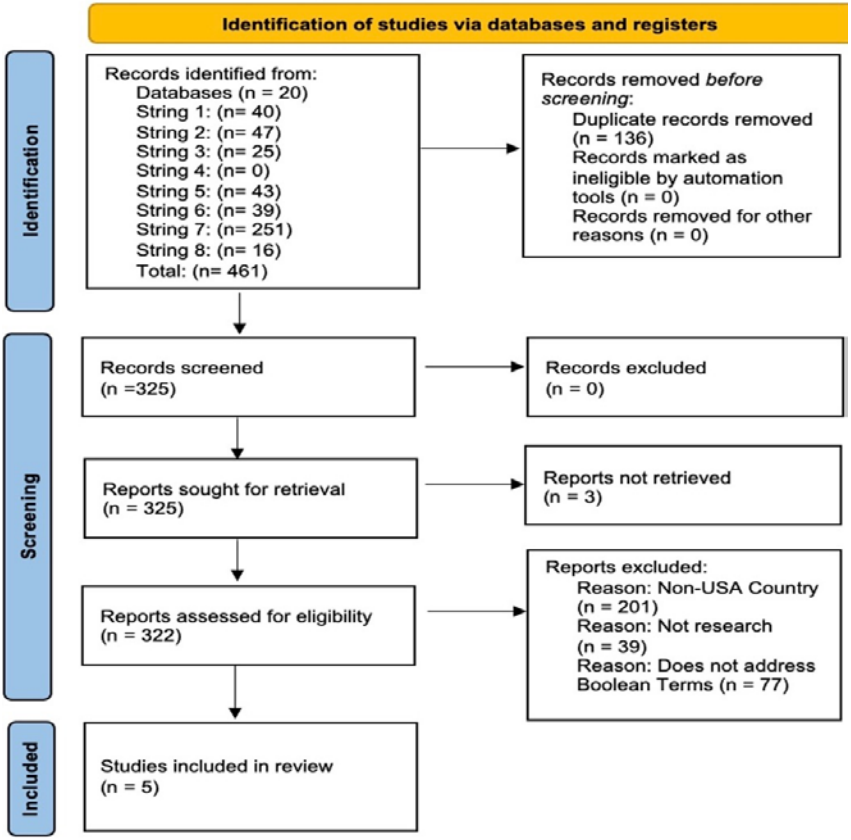

Figure 1: Inclusionary Criteria

Discussion

This systematic review, spanning from 2004 to 2021, produced five articles conducted within the USA that addressed the foundational competency of social workers regarding the process of involuntary hospitalization. However, there were no articles that addressed involuntary hospitalization competency among social work students. These findings are relevant as one cannot conclude whether social work students have or have not obtained opportunities to develop the foundational skill set expected of professionals related to the involuntary hospitalization process. While the literature acknowledges that social workers are one of the largest providers of mental health services, comprising 60% of mental health professionals (Shdaimah & O'Reilly, 2016); according to the literature, social workers are not significantly more competent than general emergency room staff (Holder et al., 2018), who may not be expected to extensively engage in the involuntary hospitalization process when compared to social workers. Holder et al. (2018) found that involuntary hospitalizations are most commonly started in the emergency department of a hospital and that social workers, physicians, and nurses in the emergency department all significantly lacked the necessary knowledge of state laws related to involuntary hospitalization. Holder et al. (2018) further found that when compared to physicians and nurses, although social workers scored the highest on an eight-question competency test, their overall score was 62.5%. Social workers were well versed regarding when involuntary hospitalization is to begin in the emergency room, the specific hours needed to begin involuntary hospitalization, and the needed criteria in discontinuing involuntary hospitalization; however, social workers were not versed on who can initiate involuntary hospitalization and whether patients involved in the involuntary hospitalization process can own firearms (Holder et al., 2018).

Another point of consideration for social work competency is explored by Reder and Quan (2004), whose findings explain that larger hospitals have access to more resources while smaller hospitals serve communities with limited resources, including limited access to social workers. Reder and

Quan (2004) identified that social workers, nurses, and doctors have limited knowledge of involuntary hospitalization due to having limited access to screening tools related to involuntary hospitalization. In addition, for those professionals that may have access, the knowledge regarding use of these tools is limited; therefore, patients are unable to receive the full benefit of the involuntary hospitalization process (Reder & Quan, 2004).

Shdaimah and O'Reilly's (2016) study found that there are definitive inconsistencies regarding the application of the involuntary hospitalization process and adherence to policies and procedures. Shdaimah and O'Reilly (2016) explain that these inconsistencies stem from lack of understanding of state statutes, absent training for staff, poor access to professional resources that could assist, and varied perceptions among the differing professions as to who among them is responsible for which stage of the involuntary hospitalization process. The research by Brodwin (2014) not only identified that a factor in the inconsistent use of involuntary hospitalization is varied perceptions of responsibility among the differing professionals; Brodwin (2014) further links ambivalence of providers directly to the provider's individual training, past experiences, and engagement in "politics of the workplace" (p. 535). The research by Hom et al. (2020) found that providers, including social workers, lack the training to work with patients at high risk of entering involuntary hospitalization, causing the provider to gather insufficient or inaccurate information during assessments; due to this, patients report feeling "belittled" and misunderstood (p. 173). Hom et al. (2020) explain the magnitude of these findings by highlighting that if the involuntary hospitalization experience is poor for the patient, it can negate any positive benefit initially sought.

The aforementioned studies illustrate that there is minimal education and training for professionals, including social workers, engaged in the involuntary hospitalization process. It is evident that failing to have education and training surrounding the involuntary hospitalization process directly causes: (a) knowledge deficits and ambivalence among providers, (b) potential of placing patients at higher risk for iatrogenic harm by placing them at increased risk for inappropriate care and poor outcomes, while (c) also

placing providers at higher risk for legal ramifications and poor therapeutic alliances due to potentially initiating involuntary hospitalization on patients that do not meet criteria under state law (Brodwin, 2014; Holder et al., 2018; Hom et al., 2020; Reder & Quan, 2004; Shdaimah & O'Reilly, 2016). Social workers, especially those who engage directly with populations that are at risk for involuntary hospitalization, must have at least a foundational knowledge of policies and procedures related to involuntary hospitalization so that they can educate patients, caretakers, and other healthcare providers about the process of involuntary hospitalization and the inherent rights patients continue to possess while subjected to this process (Holder et al., 2018). The social worker's ability to practice at micro, mezzo, and macro levels places members of the profession in a unique position, allowing them to be best suited in not only leading the charge of direct patient advocacy and education, but also conceptualizing policies that are responsive to the needs of this target population (Shdaimah & O'Reilly, 2016).

While five articles met the inclusionary criteria of this systematic review, only one of these articles quantifies the knowledge of social workers related to involuntary hospitalization. The authors of the included articles all concur that there continues to be a significant need for education and training; and while social workers were found to be more knowledgeable when compared to other professions that engage in this process, that does not equate to foundational competency (Brodwin, 2014; Holder et al., 2018; Hom et al., 2020; Reder & Quan, 2004; Shdaimah & O'Reilly, 2016). To achieve, at the very least, foundational competency, improvements must be considered to both the education provided to emerging social workers and to continued educational training opportunities for social workers currently in practice.

Involuntary Hospitalization Practice Needs Social Work Competence—A Call to Action

The results extracted from the systematic review indicate the need for enhanced social work training and education. With over 300 articles reviewed,

there are minimal findings supporting that there are foundational practice competencies for social workers regarding involuntary hospitalization. The literature reveals that competency regarding involuntary hospitalization is questionable within the social work profession. Although training opportunities may differ within the social work profession, foundational education concepts taught in schools of social work should be similar; yet the quantitative findings of Holder et al. (2018) show that there is a great need for additional education and training for those involved in the involuntary hospitalization process. This training and education is crucial because research finds that among healthcare professionals, robust educational opportunities may reduce provider ambivalence (Brodwin, 2014), increase trauma-informed care (Hom et al., 2020), increase consistency among health care providers (Holder et al., 2018; Shdaimah & O'Reilly, 2016), increase the voice of the patient throughout the process (Henwood, 2008; Hom et al., 2020), and build the community relationships needed to have a successful continuation of care (Reder & Quan, 2004). Shdaimah and O'Reilly (2016) declare that education and training have more impact on competency, when compared solely to state law adherence, surrounding use of the involuntary hospitalization processes. To support this claim, a study by Henwood (2008) found that many judges and attorneys are also inadequately prepared for involuntary hospitalization hearings and that clinical staff, including social workers, have little to no legal training related to involuntary hospitalization. Because of this, mental health professionals fail to accurately predict criteria for future involuntary hospitalizations, potentially leading to future hospitalizations that may be unnecessary or illegal. Further, unlike simple law adherence that potentially leaves much open to interpretation, education and training allow for the authentic learning needed in mastering this important decision-making process that determines civil liberties (Shdaimah & O'Reilly, 2016), as part of competency is acknowledging that there is a fine line between the right to freedom and warranted inpatient treatment (Henwood, 2008).

While exploring concepts of civil liberties, with those of autonomy versus beneficence being among the primary ethical conversations in the

literature (Cohen et al., 2018; Hotzy et al., 2019; Vuckovich & Artinian, 2005), social workers are uniquely positioned to advocate for autonomy and self-determination due to the profession's mandate to adhere to the National Association of Social Workers' Code of Ethics (Henwood, 2008). While there will likely always be a need for involuntary hospitalization, the mindful and sparing use of this legal process and its accompanying resources is best practice. Social workers have the clinical skills to assess patients in crisis, the policy skills to understand legal protocol and procedure, and the advocacy skills to protect the civil liberties of clients while supporting the delicate balance of autonomy and beneficence. The social work profession must also be mindful that legislation, such as the Mental Health Access Improvement Act, has allowed subsequent social service providers access to Centers for Medicare & Medicaid Services reimbursement (American Counseling Association, 2022). Therefore, if the social work profession is to remain at the forefront of mental healthcare, there must be an intentional plan for how the profession will bolster inpatient hospitalization process competency.

The National Association of Social Workers maintains the Code of Ethics which guides all social workers that practice within the USA and its territories to a common standard of practice (National Association of Social Workers, 2021.) By its design, this Code of Ethics implies that any ethical problems connected with concepts regarding social justice, dignity and worth of the person, and practice competency are to be viewed as integrally related; social workers should be considering involuntary hospitalization through this lens. Social workers, by trade, are everywhere people are, covering the realms of for-profit and nonprofit social welfare agencies, businesses, government agencies, educational institutions, hospitals and clinics, etc. (Nashwan & Bowie, 2018). When connected with social workers' differing roles as policy makers, advocates, and change agents, social workers are small, yet imperative components of a larger duty to actualize the promotion of social justice and maintain the civil liberties of those they serve. Social workers can provide information to help legislatures and communities understand the social problems related to involuntary hospitalization, while offering plausible evaluations of existing policies, providing recom-

mendations for system changes, and conceptualizing new policies (Weiss-Gal & Gal, 2014). Social workers are also charged with valuing the dignity and worth of a person, no matter the disability or challenge; part of this charge within the involuntary hospitalization process is helping a person understand informed consent to the best of their ability, providing information on rights, and involving agents on the person's behalf if they are unable to reasonably understand the process (Garakani et al., 2014). Structural concerns about how mental health both affects and is affected by housing, financial resources, access to care, access to family, and food stability are often overlooked (Cohen et al., 2019). Social workers, through education and training, are uniquely positioned to address the person-in-the-environment and can acknowledge structural factors along with interpersonal ones which may predict the onset of mental health crises that may lead to involuntary hospitalization. However, none of this is possible without foundational practice competency that specifically focuses on involuntary hospitalization—a skill development that may be cultivated post-graduation, but must first occur within social work education and within the practicum experience.

The Call to Action: Is Social Work Education the Answer?

So, why is the topic of involuntary hospitalization one of concern within social work education? As explained, social workers perform in varied settings which are responsible for involuntary hospitalization; while in these settings, the education and training needed for competency may not be offered, and if offered, may not meet the competency expectation of the individual practitioner's employer or that of the social work profession. Undoubtedly, agency training is a critical component to the development of social work competency; but while social work professionals will have varied agency and organizational training opportunities, it is assumed that all social work professionals share foundational competencies stemming from their social work education. Since social workers are members of multidisciplinary teams and function as a resource for consultation on the policies

and rules surrounding involuntary hospitalization, it is expected both by employers and by subsequent multidisciplinary team professionals that social workers have a foundational knowledge of involuntary hospitalization.

The Council on Social Work Education (CSWE) is the accrediting body for schools and departments of social work within the USA and its territories. CSWE is the composer of the Educational Policy and Accreditation Standards (EPAS), which provide schools of social work the base foundation of learning that all accredited schools must adhere to in an attempt to graduate social work practitioners with a common base competency. Due to CSWE formulating the EPAS into a framework that is to be considered a "competency-based education framework" (CSWE, 2022, p.7), one may also conclude that CSWE places the onus of how competencies are to be practiced upon the individual schools and departments of social work. Therefore, although the EPAS will not explicitly mandate education related to involuntary hospitalization, the EPAS certainly provides a framework where schools and departments of social work can support incorporating this skill set into advanced practice courses and/or practicum seminars—especially those programs that primarily place their students into the genres of medical social work, community social work, and any positions where interdisciplinary professions may utilize the social worker for consultation regarding involuntary hospitalization procedures.

Upon analysis of the EPAS, the document states that schools and departments of social work are responsible for developing ethical and professional behavior by assisting emerging "social workers [to] understand the role of other professionals when engaged in interprofessional practice" and "make ethical decisions by applying the standards of the National Association of Social Workers Code of Ethics, relevant laws and regulations, models for ethical decision making, ethical conduct of research, and additional codes of ethics within the profession" (CSWE, 2022, p. 8). The EPAS further outlines the importance of developing competencies surrounding the advancement of human rights and social, racial, and economic justice. According to EPAS, "social workers advocate for and engage in strategies to eliminate oppressive structural barriers to ensure that social resources, rights,

and responsibilities are distributed equitably and that civil, political, economic, social, and cultural human rights are protected" (CSWE, 2022, p. 9). Undoubtedly when policies and procedures are abused and/or misinterpreted, involuntary hospitalization can violate civil liberties and human rights, and cause a myriad of differing social injustices. This is among the varied reasons why foundational competency in the involuntary hospitalization process is imperative.

Yet another competency that the EPAS focuses on is the engagement in anti-racist, diverse, equitable, and inclusive social work practice by outlining that, "social workers understand cultural humility and recognize the extent to which a culture's structures and values, including social, economic, political, racial, technological, and cultural exclusions, may create privilege and power resulting in systemic oppression" (CSWE, 2022, pp. 9-10). The history of the practice of involuntary hospitalization does include oppression towards historically vulnerable populations (Shea et al., 2022). Because of this, social work practitioners must have, at the very least, the foundational competency needed to identify oppressive and coercive tactics used towards patients so that they may appropriately educate both patients and their families about the procedures of involuntary hospitalization, advocate on behalf of the patient in the event involuntary hospitalization practices are misused, and protect the social worker's own integrity by ensuring they only align themselves with practices that serve the best interest of their patients. Finally, and of most importance to this topic, the EPAS explicitly states that social workers must be able to "identify social policy at the local, state, federal, and global level that affects wellbeing, human rights and justice, service delivery, and access to social services" (CSWE, 2022, p. 10). To remove a patient's physical freedoms on the basis of mental health is an act where practice competency is of utmost importance. In hospital settings, it is tacit knowledge that social workers are viewed as the multidisciplinary team member that is the most versed regarding involuntary hospitalization procedures. However, most social work professionals, especially those that are new to the profession, may not have been introduced to their state's involuntary hospitalization procedures in their policy courses, practice

courses, or practicum education. Therefore, it is probable that the first interaction that a social worker has with the concept of involuntary hospitalization is within the scope of their employment; being among the same multidisciplinary team members that are themselves unsure of the correct application of involuntary hospitalization policies, processes, and procedures. Social work education and the social work profession are both in unique positions in offering all social work professionals a base knowledge and support in gaining competency on the steps and decision-making capacity needed in determining whether or not to support the decision of legally removing a person's inherent freedoms due to mental health diagnoses.

Limitations

Notable limitations of this systematic review are that: (a) there is a small sample size and (b) robust studies that addressed social work competency were not undertaken within the USA. Both limitations reflect an unfortunate gap in social work research and literature, revealing that within the USA, perhaps more attention should be given toward evaluating our practice competencies relating to social work practice skill sets that are informed by governmental laws. Countries outside of the USA, such as Australia, Canada, and the United Kingdom, place efforts upon both the evaluation of their involuntary hospitalization processes and improvement of their social work competence and practice relating to these processes, which is reflected through their research interest in critical consideration of how social work practices are applied. Once more evaluative research is performed within the United States, literature gaps may begin to narrow and perhaps the profession may better assess and articulate foundational competency needs for emerging and longstanding social work professionals.

Implications

Competency in emerging and established social work professionals regarding the practice skill set needed for involuntary hospitalization should be

one of national concern. It is evident that among medical and mental health professionals, there is both lack of knowledge on involuntary hospitalization laws and lack of available training in foundational education, continuing education opportunities, and professional training within agency and healthcare settings (Dolan & Fein, 2011; Holder et al., 2018; Hom et al., 2020; Hotzy et al., 2019; Kaufman & Way, 2010; Lincoln, 2006; Sattar et al., 2006; Shdaimah & O'Reilly, 2016). Recommendations to improve this competency must be explored.

Recommendation 1: As social workers, the authors recommend that academics, practicum education, plausible training in agencies/institutions that hire social workers, and continuing education opportunities should include inpatient hospitalization competencies; assisting all social workers with topics that explain their state's policy, procedures, and professional/employment expectations relating to involuntary hospitalization.

Recommendation 2: When considering social work education, current literature on practicum education highlights the importance of the relationship between student and supervisor, with students depending more on their practicum supervisor due to their lack of personal experience (Vassos et al., 2018). During the matching of students with placement sites, a matching of students with supervisors may have an impact on the direction of advising; meaning that a supervisor with experience in the field a student is practicing is better able to predict and prepare the student for the knowledge they need to be successful. The supervisor will also have a working knowledge of the specific challenges the student is likely to face. For example, pairing a supervisor with involuntary hospitalization skill mastery with a student placed at an inpatient mental healthcare facility, will lead to positive learning outcomes as having a closer experiential match provides more holistic support to the student. In short, if it is ensured that social work educators and supervisors have a foundational competency regarding involuntary hospitalization, it is more likely that social work students will have acquired foundational education about these concepts; hence, providing them with the best opportunity for competency mastery and practice success.

Recommendation 3: Undoubtedly, the desire to specialize is admirable, and social workers will find their place within the field where their passion meets the needs of their community. However, during their education to secure social work's terminal degree, as well as differing points of continued educational opportunities post-graduation, it is important for educators and facilitators to align the concepts of micro, mezzo, and macro social work, emphasizing the meaning of the person-in-environment model, concepts that set social workers apart from other social science professions. Creating imaginary separation of micro, mezzo, and macro or clinical and general social work responsibilities sets up emerging social workers to overlook the bigger commitment to the social work profession (Finn & Molloy, 2021), an egregious error in conceptualization that is common within the profession. To combat this error, universities have the unique opportunity to set specialty tracks where students are able to obtain general advanced practice education, while allowing the student to use elective credits to focus on foundational and/or advanced policy and practice courses on the involuntary hospitalization process. This potential curriculum consideration both reinforces the multilevel practice scope and allows for student autonomy.

Recommendation 4: Social work education can always benefit from more research which evaluates the policies and processes of involuntary hospitalization. Many students have mixed feelings related to conducting research and others do not understand the benefit beyond academic programs (Kranke, 2020). Social work programs should be encouraging research at all levels of social work education, using contemporary methods to make research meaningful to students (Kranke, 2020), and emphasizing the impact research can have on their personal practice competency as well as their career goals. Focusing on involuntary hospitalization research will engage social work researchers in the evaluation of this process, add to the body of social work knowledge, and allow for a more in-depth evaluation of potential ethical issues that influence practitioner decision making, activate practitioner biases, and affect the civil liberties of populations we serve.

Recommendation 5: Finally, social work education involves a community of support for emerging social work professionals. From classroom professors to peers, practicum supervisors, educational liaisons, site coordinators, site supervisors, etc., it can be challenging to ensure knowledge gaps are being closed. Because teaching students to apply knowledge and use decision matrices gives them invaluable career skills (Shdaimah & O'Reilly, 2016), one possible solution is providing continuing education units to social work education professionals on varied specialized topics that influence the involuntary hospitalization process, which in turn emphasizes the foundational knowledge and competence expected of the emerging social work professional. Providing monthly or quarterly options for continuing education units benefits the staff who often need these hours for licensure, the universities who need to disseminate current practice knowledge utilized within the profession, and the emerging social work professionals who are learning from practicum staff and faculty members how to apply knowledge surrounding involuntary hospitalization to practice. This recommendation may be actualized by developing an involuntary hospitalization laws and ethics course, where a content expert provides additional opportunities for knowledge and skill set development to staff while assisting them with applying/implementing this information to various course blueprints and career contexts.

In conclusion, being proactive in offering social work professionals education and training opportunities in integrating social work ethical frameworks during critical decision making, allows for the authentic development of the assessment and practice skills needed for involuntary hospitalization processes—skills that are inherently aligned with those of the social work profession as opposed to solely being task focused. With updates to education and additional training, social workers can continue to provide the high-quality services expected from both the individual practitioner and the collective profession in all aspects of involuntary hospitalization.

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Appendix 1

String 1: (social work education or training or curriculum) AND (competency or competencies or skills) AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=40**

String 2: (social work or social workers or social work practice or social services) AND (knowledge or knowledge base or education or understanding or awareness) AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=47**

String 3: (social work or social workers or social work practice or social services) AND (competency or competencies or skills) AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=25**

String 4: (“council on social work education” AND “social work core competencies” AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=0**

String 5: (mental health professionals or therapists or counselors or psychologists or social workers) AND (competency or competencies or skills) AND ("involuntary hold" or "involuntary commitment" or

"involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=43**

String 6: (mental health attorney or mental health lawyer or mental health law) AND (knowledge or knowledge base or education or understanding or awareness) AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=39**

String 7: (health professionals or healthcare professionals or health personnel or healthcare personnel or nurses or physicians) AND (knowledge or knowledge base or education or understanding or awareness) AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=251**

String 8: "council on social work education" AND ("involuntary hold" or "involuntary commitment" or "involuntary hospitalization" or "mental health hold" or "mental health commitment" or "inpatient commitment" or "involuntary mental health placement" or "emergency mental health" or committal) **Return=16**

Ethical Considerations in Civil Commitments for Substance Use Disorders

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Cynthia Nichols, MSW, Ph.D. (Candidate)
University of Connecticut
Cynthia.nichols@uconn.edu

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Abstract

In the wake of the opioid epidemic, involuntary civil commitments (ICC) for substance use disorders (SUDs) are becoming common practice. Despite SUDs being classified as a mental health condition, they are often treated differently, leading to ambiguity among states regarding the regulations and treatment of civil commitments. Although ICC is deemed to be legal, the ethics of ICC for SUD requires further consideration. Research has suggested that ICC for SUD may not be as effective as initially thought. Moreover, ICC practices among courts and treatment centers perpetuate the criminalization of substance use. Drawing on a case example from Massachusetts, this article discusses ICC using utilitarian and deontological ethical frameworks.

Keywords: Involuntary civil commitments, substance use disorders, opioid use disorder, social work ethics, utilitarian framework, deontological framework

Ethical Considerations in Civil Commitments for Substance Use Disorders

Multiple states have enacted laws that allow the use of involuntary civil commitments (ICC) for individuals diagnosed with substance use disorders (SUDs) (Cavaiola & Dolan, 2016). Civil or involuntary commitment is a legal process involving individuals with mental illness, SUD, or both, who are court-ordered to inpatient or outpatient treatment programs (Cavaiola & Dolan, 2016). ICC can be initiated by family members, health care practitioners, or other individuals for a person with a SUD (Jain et al., 2018). Although social workers are often on the frontlines of making these decisions, few studies have explored the ethical dilemmas for social workers who are initiating ICC (Taylor, 2006). While ICC can serve as a protective factor in reducing the immediate threat of overdose, ethical concerns continue to exist (Cavaiola & Dolan, 2016; Jain et al., 2018).

Previous research has primarily focused on social workers' experiences when initiating ICC for mental health reasons rather than substance use (Maylea, 2017); however, they share similar themes of ethical issues surrounding coercion (Gomory & Dunleavy, 2018; Maylea, 2017; Taylor, 2006). Although the National Association of Social Workers (NASW) (2024) ethical values provide social workers with the ideals to practice by, ethical dilemmas persist, with scholars arguing the NASW Code of Ethics is rooted in contrasting moral theories, specifically deontological and utilitarian perspectives (Bryan et al., 2016; Gomory & Dunleavy, 2018). This article aims to add to the growing body of literature addressing ICC for SUD, as well as provide social workers with a better understanding of the history of ICC and the complexities of making such decisions. Massachusetts (MA) is used as a case example to emphasize the positives and negatives of ICC for SUD. This article discusses the differences between deontological and utilitarian ethical perspectives and provides recommendations for how to balance both frameworks and manage conflicting perspectives when initiating ICC. Although all healthcare professionals do not share the same code of ethics,

utilitarian and deontological frameworks are applicable and drive many decisions made in healthcare; hence, understanding these frameworks is particularly important for social workers working with other public health professionals (Tseng & Wang, 2021).

History of Substance Use Treatment and Civil Commitments

Substance use treatment options have grown since the mid-1800s, contributing to changes in commitment laws. The Temperance Movement literature, written during the mid-1800s, began the discussion of addiction being viewed as a disease rather than a moral failure (Hall & Appelbaum, 2002). This prompted at least 14 states to pass commitment statutes for addiction between the 1860s and 1890s, in addition to 50 "inebriate hospitals" being constructed across the United States (Hall & Appelbaum, 2002). During the 1910s, there was increased interest in persons with SUD being committed and cared for within inpatient settings, prompting the creation of a national treatment facility in Lexington, KY in 1935 (Williams et al., 2014). The emphasis on inpatient settings changed during the 1960s and 1970s when states began to separately consider commitment laws for persons with SUD, causing ICC for SUD to be in outpatient or residential treatment settings (Gostin, 1991). Concurrently, states were narrowing the criteria for ICC, with greater emphasis placed on the danger posed by an individual rather than their need for treatment. In the 1980s, the American Psychiatric Association (APA) countered this change with the 1983 Model State Law, arguing for the need for treatment, which led states to widen their criteria to include risk of severe deterioration and the inability to care for self (Williams et al., 2014).

Initial ICC laws emphasized the importance of a supportive, long-term treatment environment to allow individuals to stabilize. One of the first civil commitment laws to address individuals with SUD was the Marchman Act, passed in 1993 in Florida (Cavaiola & Dolan, 2016). The Marchman Act provided civil commitment for up to 7 days or longer-term treatment for those with severe SUD (Cavaiola & Dolan, 2016). This law allowed for mandatory

treatment where individuals could be assessed and stabilized through detox, medication-assisted treatment, and medical stabilization, as well as encouraging longer-term treatment (Cavaiola & Dolan, 2016). The Marchman Act contended that treatment may provide time for individuals to regain rational decision-making, which may be lacking due to the nature of SUD (Cavaiola & Dolan, 2016).

The Opioid Epidemic

Presently, substance use is one of the leading causes of morbidity and mortality in the US (Christopher et al., 2015). Increases in prescription opioid use, heroin, and fentanyl have contributed to a rise in overdose deaths. Drug overdoses have claimed over one million lives since 1999, with opioids involved in 80,411 overdose deaths in 2021 (Centers for Disease Control and Prevention (CDC), 2023). In addition to substance use being a significant public health and safety issue, it poses economic consequences (Christopher et al., 2015). In the US, substance use is believed to have an economic impact ranging from $193 billion for illicit drugs to $223.5 billion for alcohol (Bouchery et al., 2011).

An increase in opioid prescriptions can be traced to the 1990s when two critical shifts in practice occurred: (1) the use of opioids for pain management expanded to non-cancer patients, and (2) Purdue Pharma received Food and Drug Administration (FDA) approval for Oxycontin (Krans & Patrick, 2016). As opioids were over-prescribed, patients became addicted, leading to an increase in heroin use and overdose deaths (Krans & Patrick, 2016; Rudd et al., 2016). Other factors contributing to opioids being more accessible were black tar heroin being less expensive on the illegal market, and the creation of "pill mills" by corrupt doctors who dispensed prescriptions for cash and other goods (Quinones, 2015). Since 2013, overdose deaths involving synthetic opioids have been on the rise, particularly those involving fentanyl (O'Donnell et al., 2017).

For many years, voluntary treatment for SUD has been the only option for individuals struggling with substance use outside of the context of the

criminal justice system (Cavaiola & Dolan, 2016). Although voluntary treatment for SUD is often more desirable due to increased patient autonomy, mandated treatment is effective in certain instances (Farabee et al., 1998; Kelly et al., 2005). Research has found that offenders mandated to SUD treatment demonstrated similar or improved substance use outcomes as well as crime reduction, compared to those who entered SUD treatment voluntarily (Kelly et al., 2005). Drug courts, which are specialized dockets for criminal offenders with SUD, are a common example of mandated treatment, with SUD treatment often required to avoid incarceration (Cavaiola & Dolan, 2016). Drug courts have been useful in diverting nonviolent offenders away from the criminal justice system and into SUD treatment; however, drug courts are, in many jurisdictions, only applicable for individuals who have been convicted of a drug-related charge (Fulton Hora, 2002). ICC for SUD is another type of mandated treatment with similar aims of reducing risks related to substance use, including overdose and criminal involvement.

Civil Commitments for Substance Use Disorders

Many states are turning to ICC as a solution in addressing the opioid epidemic and increasing access to treatment. In 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis issued a report providing recommendations on how to address the addiction crisis (Christie et al., 2017). This report revealed that 90% of people with SUD (including 17 million American adults) did not believe specialty substance use treatment was needed (Christie et al., 2017). Furthermore, of the more than 20 million Americans diagnosed with a SUD under the Diagnostic and Statistical Manual of Mental Disorders (DSM), only two percent of that number have received substance use treatment, with under one percent receiving care from a facility that specialized in substance use treatment (Christopher et al., 2015). These statistics suggest that many individuals do not recognize the importance of substance use specific treatment, or do not wish to pursue treatment (Christopher et al., 2015; Jain et al., 2018).

Given the low rates of interest in treatment, external influences are often involved in treatment initiation, including family pressure, mandates by work or legal influences, including jail diversion and drug courts (Christopher et al., 2015). ICC for substance use occurs when an individual is court-ordered to a period of treatment, which occurs separately from criminal confinement and other forms of civil commitments (Klag et al., 2005). ICC laws have been enacted by several states in response to the concerns of family, significant others, and friends when a loved one is using substances (Cavaiola & Dolan, 2016). Family and friends of those misusing opioids are often faced with the difficult reality that if they wait until their loved one is willing to voluntarily enter treatment, their loved one may face overdose and death (Cavaiola & Dolan, 2016). ICC laws for substance use have been adopted in 38 states as a way of mandating individuals with severe SUD to enter treatment (Cavaiola & Dolan, 2016; Slocum et al., 2023).

In ICC cases, concerned individuals may petition the court to enforce a mandate for a person with a severe SUD to enter treatment (Christopher et al., 2015). Rather than a criminal charge, the petition allows the court to issue a ruling (Walton & Hall, 2017). The petition process is started by a concerned person providing supportive information that justifies reasons the defendant's substance use is severe enough for emergent treatment to be warranted, and they are at risk of harm to themselves or others (Walton & Hall, 2017). Typically, statutory requirements include that a medical professional evaluate the person with the SUD and certify, in writing, that the person needs intensive treatment, accompanied by the commitment petition (National Judicial Opioid Task Force, 2019). The status governing ICC vary by jurisdiction, with criteria commonly including dangerousness to oneself or others, grave disability, lack of decision-making capacity, inability to manage personal affairs and take care of basic needs, and loss of control due to addiction (National Judicial Opioid Task Force, 2019).

If a judge grants the petition, the ICC process would occur, meaning the individual would be mandated to SUD treatment (Walton & Hall, 2017). To protect the civil rights of the person with the SUD, every state allows the right to an attorney during the commitment process, and the right to

petition the court for a writ of habeas corpus, which is a right that protects against unlawful and indefinite imprisonment (American Civil Liberties Union, 2007; National Judicial Opioid Task Force, 2019). Statutes vary in the type of punishment imposed for individuals resistant to treatment, as well as ICC commitment length and location (Walton & Hall, 2017).

Presently, disagreement exists regarding the nature and treatment of SUD within the medical community, leading to variability among state statutes of ICC laws for SUD (Williams et al., 2014). Every US state has adopted laws that allow individuals with mental health issues (those at risk of harming themselves or others, or danger to self as a result of a grave disability) to be involuntarily committed; although, specifics regarding these laws are variable by state (Williams et al., 2014). Despite SUD being classified as a mental health condition, SUD ICCs are often addressed differently, meaning the commitment process is different from commitments for other mental health reasons, which are typically carried out in an inpatient psychiatric unit (Testa & West, 2010). Whereas some states, such as Maine, have already included SUD under their eligibility criteria in ICC laws for mental health issues, others, such as Kentucky, have specifically created separate ICC laws for those with SUD (Walton & Hall, 2017).

Furthermore, civil commitment laws differ in the length of confinement and the type of treatment setting, either outpatient or inpatient (Cavaiola & Dolan, 2016). For example, Arizona has commitment durations of 90, 180, and 365 days, while Massachusetts has a 90-day duration (Cavaiola & Dolan, 2016). In addition to having a 90-day duration, MA utilizes settings outside of typical therapeutic environments for substance use ICC.

Massachusetts Case Example

Opioid-related overdose deaths rose in MA in 2022 by 2.5% compared to 2021, with 2,357 deaths in 2022 and the largest increase in deaths occurring among Black and non-Hispanic residents (MA Department of Public Health, 2023). Non-Hispanic Black residents had the highest opioid-related

overdose death rate increase from 2021 to 2022, from 56.4 to 79.6 per 100,000, while non-Hispanic women increased from 17.4 to 25.5 per 100,000 (MA Department of Public Health, 2023). Furthermore, in 2020, opioid related deaths in MA were 33% higher than the national average (Slocum et al., 2023).

In MA, petitions for ICC are under the MA General Law Chapter 123, Section 35, commonly called "Section 35 Petitions" (Munichiello, 2019). Section 35 was enacted in 1970 which allows a qualified person (i.e. physician, police officer, court official, or blood relative) to petition the court to have a person involuntary committed for SUD (Slocum, 2023). Individuals are sectioned into various facilities overseen by the Department of Public Health (DPH), the Department of Mental Health (DMH), and the Department of Correction (DOC) (Becker, 2019). MA is the only state that uses correctional institutions for ICC when no crime is involved (Becker, 2019). As of 2019, if there are not any suitable licensed or DPH or the DMH approved treatment facilities available, and if the court finds the only appropriate setting is within a secure facility, then a person may be committed for "(i) a secure facility for women approved by the DPH or the DMH, if a female; or (ii) the MA correctional institution at Bridgewater or other such facility as designated by the commissioner of correction, if a male; provided, however, that any person so committed shall be housed and treated separately from persons currently serving a criminal sentence." (The General Court of the Commonwealth of MA, 2023, para. 7). Previously, women also had the potential to be committed to a correctional facility, but this changed in 2019. Currently, all the facilities women are committed to are overseen by either DPH or DMH, whereas two of the three facilities for men are overseen by DOC (Becker, 2019).

In 2019, MA Governor Charlie Baker created a Section 35 Commission to evaluate the efficacy of ICC for SUD (Munichiello, 2019). According to this report, the Men's Addiction Treatment Center (MATC) in Brockton was the only Section 35 facility overseen by DPH and MA Alcohol and Substance Abuse Center (MASAC), and the largest men's facility was run by the DOC (Munichiello, 2019).

The Commission's report revealed stark differences between these two settings, including differences in types of medications for opioid use disorder (MOUD) offered. MOUD is an evidenced based treatment for individuals with opioid use disorder (OUD) (Degenhardt et al., 2011; Larochelle et al., 2018; Ma et al., 2019). Commonly used MOUD include buprenorphine, methadone, naltrexone, and injectable options (Sublocade and Vivitrol) (Substance Abuse and Mental Health Services Administration (SAMHSA), 2022). The use of MOUD has been shown to increase treatment retention and employment, and decrease criminal behaviors (SAMHSA, 2022). Although all four of the Section 35 facilities offer buprenorphine and naltrexone, MATC was the only facility licensed to offer methadone (Munichiello, 2019). According to a 2018 study in MA, only 19% of individuals who had been civilly committed for OUD received MOUD (Christopher et al., 2018).

Additionally, one-third fewer therapy services were offered at MASAC compared to MATC (Munichiello, 2019). Furthermore, correctional procedures at MASAC interfered with a treatment-centered approach; this included patients being instructed to stand at the foot of their bed and remain standing while officers counted them (Munichiello, 2019). The treatment at MASAC and MATC has also been described as "night and day," with MASAC staff consisting of 100 correctional officers (with no special training), and only 17 substance use counselors (Munichiello, 2019, para. 10). MASAC patients also experience strip searching upon admission, solitary confinement for punishment, and report officers using abusive language, threats, and intimidation, all of which were not reported at MATC (Munichiello, 2019).

Since the Commission's report, in November 2022, Section 35 regulations were amended to mandate access to MOUD in any civil commitment facility in MA; however, there have been no studies assessing implementation of these changes (Slocum et al., 2023). Other reports have revealed that individuals committed to carceral settings have been placed in solitary confinement for refusing food, lost access to psychiatric medications, and experienced irreversible trauma from these experiences (Slocum et al., 2023).

Ethical Legislative Precedents

ICC laws have originated from two roles or functions of the state, specifically police powers (meaning the government's ability to enact laws to coerce citizenry for public good) and *parens patriae* (meaning "parent of the fatherland") (SAMHSA, 2019). Police powers protect citizens from harmful substance-related behaviors (driving under the influence), while *Parens patriae* is a legal doctrine that allows the state to act *in loco parentis,* meaning "in place of a parent", when citizens are incapable or lack capacity to act on their behalf (Walton & Hall, 2017). Essentially, the court can suspend an individual's right to freedom and require that they enter treatment so they may recover, in order to protect the safety and health of individuals and communities (Walton & Hall, 2017).

Several cases have formed the legal basis for ICC laws. Lawmakers have decided that specific health conditions are dangerous enough to permit nonconsensual intervention, including mental illness, tuberculosis, and guardianship (Bayer & Dupuis, 1995; Monahan et al., 1995; Teaster et al., 2007). A set of provisions ensures that authorities do not abuse their authority in ICC cases, including prioritizing the least restrictive means, entailing strict time limitations on ICC, and requiring the burden of proof from the petitioner (SAMHSA, 2019; Walton & Hall, 2017).

Previous legal cases have shaped ICC laws, including *Robinson v. California, 370 U.S.660 (1962)*, *O'Connor v. Donaldson, 422 U.S. 563 (1975)*, and *Addington v. Texas, 441 U.S. 418 (1979)* (*Addington v. Texas, 441 U.S. 418*, 1979; *O'Connor v. Donaldson, 422 U.S. 56, 1975*; *Robinson v. California, 370 U.S. 660, 1962*). In each of these cases, the rulings offered guidance about what constitutes a person being at harm to themselves, and when it is no longer appropriate for them to remain in treatment.

In *Robinson v. California, 370 U.S.660 (1962)*, Lawrence Robinson was convicted and sentenced to 90 days after being pulled over by the police who noticed marks on Robinson's arms from substance use; however, this was struck down based on the conviction being a violation of the Eighth Amendment and Fourteenth Amendment due to their being insufficient

evidence of harm (Walton & Hall, 2017). In this case, Justice Tom C. Clark began the discussion of there being two stages of drug use, including voluntary use and then involuntary use (Walton & Hall, 2017). He advocated for state laws to begin transitioning laws from treating individuals as criminal to sick once they are unable to control their substance use, suggesting that the state use its police powers to protect individuals from becoming involuntary drug users (Walton & Hall, 2017).

Furthermore, *O'Connor v. Donaldson, 422 U.S. 563 (1975)* and *Addington v. Texas, 441 U.S. 418 (1979*) rulings emphasized the importance of there being clear and convincing evidence that a person is at harm to themselves for the state to enforce an ICC (Walton & Hall, 2017; SAMSHA, 2019). *O'Connor v. Donaldson, 422 U.S. 563 (1975)* occurred when Kenneth Donaldson was involuntarily committed by his parents for a delusional disorder from 1957 to 1971. He petitioned the court 18 times arguing that he was not a danger to himself or others (Walton & Hall, 2017). The Supreme Court eventually ruled in favor of Donaldson, stating that the requirement of imminent threat of harm to self or others is necessary for a state to enforce future ICC laws, and that states have the ongoing responsibility to defend the commitment (SAMHSA, 2019).

Lastly, in *Addington v. Texas, 441 U.S. 418 (1979*), Frank Addington was indefinitely confined to a psychiatric hospital after he threatened his mother. Although Addington was diagnosed with schizophrenia, he contested that his providers had not provided sufficient burden of proof (Walton & Hall, 2017). Ultimately, the courts decided that an intermediate condition of proof (clear and convincing evidence), should be applied versus a stringent condition (beyond a reasonable doubt) (Kaplow, L., 2011). Hence, the courts acknowledged that even highly trained and skilled mental health professionals cannot predict future dangerous behaviors (Ross, 1979).

Overall, these judicial rulings supported the notion that citizens' rights should temporarily be suspended to protect themselves and others from harm, but only when there is clear and convincing evidence (Walton & Hall, 2017). These cases also emphasize tendencies to involuntarily commit a

person when there is fear of a future incident or concern of a person being dangerous.

Utilitarian and Deontological Ethics

Although ICC laws may be legal, the pathways and settings in which they occur are not always ethical. Arguments that oppose ICC tend to focus on individual rights-based assertions grounded in classical libertarian ideology (Walton & Hall, 2017). Libertarian ideologies tend to stress individual rights, specifically that each individual should have freedom unless their behavior violates other individuals' freedoms (Walton & Hall, 2017). Conversely, arguments that favor ICC tend to share beliefs with communitarian ideologies, which emphasize the importance of protecting the rights of communities and other social groups (Walton & Hall, 2017).

The libertarian and communitarian ideologies of ICC are similar to the utilitarian and deontological theories of ethics frequently discussed within medical decision-making. Like communitarian ethics, in the utilitarian approach, decisions are based on the calculated harms or benefits of action to have the most significant benefit for the greatest number of individuals (Mandal et al., 2016; Osmo & Landau, 2006). Conversely, similar to libertarian ideology, deontology theory suggests a patient-centered approach, where harm is unacceptable regardless of consequences (Mandal et al., 2016). Although healthcare providers typically aim to follow deontological ideologies, systems and administrators are likely to encourage using a utilitarian framework to avoid and reduce consequences to as many individuals as possible (Mandal et al., 2016).

Research has also shown that although social workers are more deontological in principle, they tend to utilize a more utilitarian approach in practice situations (Osmo & Landau, 2016). For example, NASW (2024) social work ethics speak to the importance of prioritizing clients as evidenced by the social work value of service, and dignity and worth of a person; however, social workers also have a responsibility to society. Hence, in healthcare settings, social workers are balancing person-centered approaches and broader concerns, including the potential impact of the harm

that a person's SUD can create for a community and other individuals. Concerns about liability may be a potential reason for this.

There are benefits to utilizing both deontological and utilitarian approaches in making ICC decisions, as both patient and societal needs should inform providers and courts when debating ICC decisions. Understanding the concerns and justifications of ICC is valuable in making an ethical decision about when to use an ICC for SUD. The remainder of this article will apply utilitarian and deontological ethical frameworks to clarify the ethical concerns and justifications for ICC. Finally, an ethical solution that balances these concerns and justifications will be offered.

Ethical Concerns

The use of ICC for SUD can violate ethical principles outlined within the NASW Code of Ethics (2024); specifically, the core ethics of respecting and promoting a clients' right to self-determination, non-maleficence, beneficence, and justice. Given that not all ICC settings are therapeutic, particularly carceral settings, social workers may do more harm than good by initiating an ICC. Furthermore, ICC can be coercive and negatively impact a person's autonomy, particularly if other treatment options have not been explored. Lastly, gender and racial disparities exist among ICC that can perpetuate structural inequities. Social workers must consider these principles in upholding NASW core values, including the value of integrity. A deontological framework can be useful in encapsulating the multiple ethical principles and values contemplated by social workers when deciding if an ICC is needed or when working with other providers initiating an ICC.

Using a deontological approach when considering ICC for SUD is valuable due to the treatment setting variability among ICC sentences, as seen in MA. Research suggests that social workers and other healthcare providers in MA may already be using a deontological framework as they have expressed concerns over current ICC pathways and locations (Walt et al., 2022). For example, a study by Walt et al. (2022), interviewing clinicians in MA, revealed that the majority of clinicians experienced some or high levels

of moral distress when utilizing Section 35 (ICC for SUD) for involuntary commitment. These clinicians expressed concerns about systemic treatment failures, and believed SUD should be viewed through a harm reduction framework (Walt et al., 2022). They also expressed concern about the treatment settings employed in the Section 35 process, including criminal justice settings (Walt et al., 2022). These findings suggest providers are inclined to take a patient-centered approach that considers the potential consequences of ICC to the individual with SUD in concert with the individual's preference to remain in the community over the potential, albeit unpredictable, harm of not using ICC.

Concurrently, another concern of ICC for substance use is that providers and court systems may have different thresholds in deciding what types of behaviors warrant an ICC. Subjectivity in providers' feelings about SUD, and the inability to predict future behavior, can contribute to individuals facing an ICC sentence when other treatment options have not been exhausted (Walton & Hall, 2017). Specifically, the stigma of SUD has contributed to providers resisting harm reduction practices that have been shown to save lives, including syringe exchange programs, safe consumption sites, and naloxone kits (Messinger & Beletsky, 2021; Walton & Hall, 2017). A study surveying emergency room providers in three New England academic care centers found that although providers reported an interest in engaging patients in harm reduction services, less than 10% did so in practice (Samuels et al., 2016). Provider resistance to harm reduction treatments may contribute to some pursuing an ICC sentence to coerce clients to engage in abstinence-based treatment.

Other literature has demonstrated inconsistencies in the efficacy of ICC for SUD, revealing that involuntary commitment may create unintended consequences (Evans et al., 2020; Messinger & Beletsky, 2021). For example, in 2019, the MA DPH found that individuals subjected to involuntary treatment were 2.2 times more likely to die from overdose than those who attended voluntary treatment; however, it is unknown how these results compare with those who did not receive any treatment (Messinger & Beletsky, 2021). Furthermore, the criminalization of ICC has become a

growing concern due to ICC patients being detained by the police, handcuffed in courtroom proceedings, or held in lockup (Christopher et al., 2020). The safety of ICC facilities has also been questioned, with there being recent findings of escape attempts, suicides, and other tragic events (Messinger & Beletsky, 2021). This suggests that ICC facilities may be retraumatizing a population that frequently has comorbid Post Traumatic Stress Disorder (PTSD), and significant trauma histories (Gielen et al., 2012). Lastly, issues related to ICC facilities have been exacerbated by the COVID-19 pandemic and the elevated risk of COVID-19 transmission in these settings (Sinha et al., 2020).

Another ethical concern of ICC is that variability exists in treatment among ICC treatment settings. No statutes are established that serve as precedence for ICC facilities' standards of care during treatment, with many ICC facilities neglecting to use empirically validated treatments (Messinger & Beletsky, 2021). The majority of ICC facilities fail to provide FDA-approved MOUD, and do not connect individuals to community-based treatment upon release (Evans et al., 2020; Messinger & Beletsky, 2021). A study by Christopher et al. (2018), found that less than 20% of individuals in ICC facilities received MOUD, and only 7% followed up with treatment after their release. Additionally, it was found that 34% of respondents reported relapsing to drug use the day they were released from ICC, further emphasizing the need for relapse prevention treatments, including MOUD (Christopher et al., 2018).

Literature has revealed that former patients of ICC are aware of its short-comings and may be more likely to avoid treatment in the future. Christopher et al. (2020) found that individuals previously committed for opioid misuse were less likely to support drug misuse-related ICC due to its perceived lack of efficacy, and had more favorable views toward ICC for mental health reasons rather than for drug misuse. Similarly, previous studies have suggested that ICC for mental health reasons may impact future help-seeking behaviors; for example, Swartz et al. (2003) found that individuals with a history of involuntary hospitalization for mental health issues were less likely to seek out outpatient treatment in the future due to fear of

coercion. This may also be true among individuals with SUD; however, further research is needed.

Lastly, ICC for SUD raise multiple social justice issues (McLeod, 2024). Differences between state ICC statutes, practices, and settings are likely to contribute to health inequities, including discrepancies in future substance use treatment utilization. As discussed previously, women are no longer sectioned to carceral settings in MA; hence, differences in treatment settings are likely to contribute to gender disparities. Furthermore, a recent study in MA found men civilly committed for opioid use reported longer wait times between ICC hearing and treatment setting transfer compared to women (Hayaki et al., 2023). Men also had longer wait times for opioid withdrawal management compared to women (Hayaki et al., 2023). These findings suggest the treatment of men and women is different throughout the ICC process, potentially contributing to worse outcomes among men.

Although there is limited literature addressing racial disparities in ICC for SUD, research has found that Black, Indigenous, People of Color (BIPOC) are more likely to be subjected to involuntary psychiatric hospitalization compared to white patients (Shea et al., 2022). More research is needed to understand racial disparities in ICC for SUD commitment process and practices. Given that substance use has historically been criminalized more among BIPOC populations receiving drug charges, social workers must be weary of differences in treatment among racial groups and pause before initiating ICC for SUD (Rosino & Hughey, 2018).

Ethical Justifications

Utilitarian frameworks are beneficial in understanding the possible benefits linked with an ICC admission, particularly due to the harms associated with ongoing substance use. Justifications for ICC are concurrent with NASW ethical principles of non-maleficence, beneficence, as well as values of dignity and worth of the person, and integrity (NASW, 2024).

The scientific community has argued that SUD is a chronic condition with biological, genetic, and neurological mechanisms (Leshner, 1997). In

most civil commitment laws, the rationale is that it is unreasonable to expect individuals with severe SUD to provide informed consent to enter voluntary treatment due to negative effects of ongoing substance use, including impaired insight and compromised capacity to make rational decisions (Cavaiola & Dolan, 2016). One of the criteria for SUD is that substance use continues despite awareness of recurrent physical or psychological problems that have been caused or worsened by the substance (American Psychiatric Association, 2022). Hence, it is argued that individuals with SUD may lack the ability to recognize their level of impairment and enter treatment, as the individual can perceive this as interfering with short-term gains of substance use (Cavaiola & Dolan, 2016). Furthermore, research has revealed that individuals with OUD may not have the ability to provide voluntary informed consent to treatment due to the disorder progressing and individuals losing the ability to make rational decisions (Charland, 2002).

Hence, ICC may be considered a step that generates motivation for a person to continue their recovery following a period of stabilization where they are unable to use substances. A period of stabilization has the potential for individuals to make more rational decisions regarding future treatment (Cavaiola & Dolan, 2016). Positive experiences within ICC, and the procedural process, can impact post-commitment abstinence length. For example, Christopher et al. (2018) revealed that when individuals have positive ICC experiences, including higher perceived procedural justice during the commitment hearing, and have post-commitment medication treatment, they tend to have more extended periods of abstinence.

Others argue that ICC prevents overdose, saves lives in the short term, and protects vulnerable and underserved populations (Evans et al., 2020). Specifically, Evans et al. (2020) found that ICC provided immediate access to OUD treatment, which was not readily available in community-based treatment due to long wait lists, strict treatment policies, and lack of long-term care. Participants also reported arranging involuntarily commitment themselves for the support and treatment engagement (Evans et al., 2020). Lastly, a recent study in Australia revealed that individuals receiving involuntary and voluntary treatment had the same reduction in emergency

department visits a year following admission for severe alcohol use disorder (Vuong et al., 2022). Although this study revealed positive outcomes for involuntary treatment, it is unclear what type of settings Australia commits individuals to, and how this may impact their experiences and healthcare utilization.

Finally, ICC has been identified as helpful in diverting individuals with SUD from the criminal justice system (Cavaiola & Dolan, 2016). Christopher et al. (2018) found that most individuals receiving ICC were considered high-risk, reporting histories of intravenous heroin and fentanyl use, as well as overdose and current criminal justice involvement. Seeing that many of the individuals with an ICC are in danger of continued criminal justice system involvement with other risk factors, therapeutic ICC may reduce high-risk behaviors perpetuating this cycle. Avoiding criminal convictions can also reduce barriers to employment, credit, and housing (Clark, 2007; Henderson, 2005; Saxonhouse, 2004). Other research has revealed additional communal and individual benefits associated with ICC, including increased patient gratitude, increased treatment options for families, increased treatment access, and promotion of public health and public safety, such as the prevention of Hepatitis C and other infectious diseases (Evans et al., 2020). Hence, it can be argued that there are more benefits associated with ICC admissions than consequences.

Ethical Solutions

As fatal overdoses increase, and as ICC becomes a common practice among providers and courts, additional education and careful ethical considerations must occur. And, while scholars frequently discuss utilitarian and deontological frameworks in contrast to one another, in practice, the two are used in conjunction depending on the circumstance. For instance, the provider and patient relationship is deontological, but providers are often forced to utilize a utilitarian framework during times of crisis to reduce potential consequences to as many individuals as possible and increase safety (Vearrier & Henderson, 2021). For example, the individual using substances

may continuously commit acts that are potentially harmful to the community while intoxicated, such as operating automobiles or other potentially dangerous behaviors, and the provider feels obligated to initiate an ICC for SUD due to protect others from harm. On the other hand, providers often adopt a utilitarian approach when facing pressure to reduce the likelihood of overdose and other dangers of substance use through ICC, but do not realize the negative impact this may have for patients' future mental health symptoms and healthcare utilization behaviors. Reducing the harms associated with both continued, unabated substance use and ICC requires that these frameworks be used concurrently. Table 1 below outlines the considerations from each framework and the balance point between the two that offers an ethical solution for determining the use of ICC.

Justification	Concern	Potential Solution
Can provide a period of stabilization (Cavaiola & Dolan, 2016).	Can exacerbate symptoms for individuals with trauma histories (Gielen et al., 2012).	Utilize both utilitarian and deontological approaches in ICC decision making, ensuring all other treatment options have been exhausted and individual factors are considered.
Can provide immediate access to OUD treatment (Evans et al., 2020).	Variability in ICC laws among states with some neglecting empirically validated treatments (Messinger & Beletsky, 2021)	Creation of ICC standards of care, including ICC providing MOUD.
Can reduce risks of SUD, including overdose (Evans et al., 2020).	Can contribute to increased risk of overdose following discharge (Cavaiola & Dolan, 2016).	Ongoing research investigating efficacy of ICC.
Can be a motivating factor for continued treatment (Christopher et al., 2018).	May reduce future healthcare utilization (Christopher et al., 2020; Swartz et al., 2003).	Continued education and supervision from healthcare settings and supervisors about ICC.
Can divert individuals away from criminal justice system (Cavaiola & Dolan, 2016).	Variability in ICC settings, specifically the use of criminal justice systems (Evans et al., 2020; Messinger & Beletsky, 2021)	Continued guidance from states about how to construct, implement, and enforce ICC laws; including, ICC settings only being in healthcare and therapeutic settings.

Table 1: Justifications, Concerns, and Solutions of ICC for SUD

Although there is more evidence suggesting ICCs for SUD to be unethical in certain settings, steps can be taken to increase efficacy and improve patient outcomes. First, ICC recommendations should never be initiated without careful consideration by a provider, and should only be made as a last resort after all other options have been exhausted (Cavaiola & Dolan, 2016; Evans et al., 2020). Utilizing a deontological approach and considering each client's values and preferences is critical in developing a therapeutic relationship and understanding whether ICC is the most appropriate choice for an individual. Due to biases among mental health professionals and other providers, supervision should be sought prior to a provider making an ICC recommendation. Additionally, providers should regularly attend ICC educational trainings, which include information about the ethics of ICC, the chronic nature of addiction, and harm reduction practices (Jain et al., 2021).

ICC programs should not occur in criminal justice settings and should instead occur only in healthcare settings (Evans et al., 2020). Research has shown that abstinence occurs for more prolonged durations following ICC when individuals report positive experiences within ICC settings, which is often lacking within correctional facilities (Christopher et al., 2018). Treating SUD within correctional facilities also clashes with many healthcare professionals' codes of ethics, including social work's ethic of respecting the inherent dignity and worth of a person (Evans et al., 2020). Furthermore, ICC standards of care should be created to support the use of FDA-approved MOUD, as individuals using approved medications have lower mortality, less opioid use, and less infection disease risk (Evans et al., 2020). The use of FDA medications within ICC would also have the potential to reduce the risk of overdose following ICC admissions.

Other systemic changes should occur to increase access to evidence-based approaches prior to an ICC for SUD. It would be valuable to increase accessibility to other substance use treatment options, as this may decrease the number of ICC recommendations and improve outcomes upon discharge from ICC (Reif, 2017). Increasing access should include using harm reduction strategies and expanding the number of treatment venues to emergency and primary care settings (Sinha et al., 2020). For example,

creating "bridge clinics" in Boston has been valuable in allowing clinicians to initiate buprenorphine treatment in emergency departments and connect patients to follow-up care (Sinha et al., 2020).

Additional research addressing the efficacy of ICC for SUD is needed, given the insufficient knowledge regarding how states should construct, implement, and enforce ICC laws, as well as the variability between state ICC laws (Walton & Hall, 2017). It would be valuable for researchers and policymakers to identify a measurable goal of the ICC, which would help frame how states should implement ICC laws and duration (Walton & Hall, 2017). Other questions must be examined, including what type of individual benefits from an ICC, whether ICC has better outcomes than other policies, and the short- and long-term accumulative effects of an ICC (Evans et al., 2020). Recent literature has assessed practices within certain states, specifically MA; however, more research is needed to understand the type of treatment provided in other states for ICC and the coordination of care between providers in these settings and outside of these settings (Christopher et al., 2015; Christopher et al., 2018, Slocum et al., 2023). Lastly, past research has primarily explored family, police, and some healthcare providers perspectives of ICC for SUD; however, more research is needed to understand the perspective of social workers and the specific dilemmas they face in making these decisions (Husted & Nehemkis, 1995; Slocum et al., 2023).

Each of these factors should be considered when social workers recommend a civil commitment to a physician or family member. While many of these ethical concerns are related to systemic issues, it is important that social workers are aware and have education around these issues to make informed decisions when weighing the harms associated with ongoing substance use for a client and the community versus the potential harms of ICC practices and settings. Social workers must continue to practice the NASW value of competence and develop their professional expertise of ICC as literature about this process increases. Lastly, social workers must continue to advocate and challenge the social injustices occurring among ICC settings which violate a person's dignity and worth and perpetuate gender and racial inequalities and inequities.

Conclusion

Overall, ICC for SUD has the potential to be a valuable lifesaving recovery resource for individuals with severe SUD who are at risk of harmful behaviors and criminal justice involvement. Despite the justifications for ICC, variability in ICC laws and settings are cause for concern and may reduce future healthcare utilization, exacerbate mental health symptoms, and increase the risk of overdose. To reduce these risks, utilitarian and deontological approaches should be used in conjunction among healthcare providers and social workers, in order to make ethical decisions regarding the utility of ICC for individuals and the surrounding community. Ongoing research regarding the efficacy of ICC is warranted, as well as continued guidance from states regarding ICC laws, settings, and standards of care.

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Forum: Is it Unethical to Employ Freudian Theory in Clinical Social Work?

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Stephen M. Marson, Ph.D. ACSW
Professor Emeritus, UNCP
smarson@nc.rr.com

Paul Dovyak, ACSW, BCD
University of Rio Grande
pdovyak@rio.edu

Marson, S. & Dovyak, P. (2024). Forum: Is it Unethical to Employ Freudian Theory in Clinical Social Work? *International Journal of Social Work Values and Ethics*, 21(2), 174-184. https://doi.org/10.55521/10-021-211

Abstract

The threads of Freudian theory are introduced within our history of clinical social work. This excursion provides the foundation for assessing the relevance and contributions of Freud. Although we begin by assessing and questioning the ethical employment of Freudian theory within clinical social work, we end with the acknowledgement that Freudian theory is deeply ingrained within most facets of clinical social work. Acknowledging that Freudian concepts such as "penis envy" have lost credibility doesn't take away from the relevance and importance of many of Freud's mainstream therapeutic concepts.

Keywords: Freudian theory, clinical social work, intervention theory, ego psychology, theoretical credibility

Historical Foundation

In the 1960s and early 70s, the dominant conceptual framework for clinical social work (then called "psychiatric social work") was Freudian. Even then,

the use of Freud's name had fallen out of grace and was replaced with the term "ego psychology." During this timeframe, two books dominated the MSW curriculum:

- Blanck, G., & Blanck, R. (1974). *Ego psychology: Theory and practice*. Columbia University Press.
- Lidz, T. (1968). *The person: His development throughout the life cycle*. Basic Books.

Blanck and Blanck (1974) was a theoretically-based practice textbook that provided a conceptual framework for addressing a wide range of general mental health issues faced by social work clients. Lidz, on the other hand, was a textbook for social work and the Human Behavior and Social Environment (HBSE) curriculum. The first edition of the Lidz text was overtly chauvinistic -- to the point that the book's content made young male students cringe. Professors who adopted Lidz were often challenged by their students. Professors retorted by stressing that *The Person* was the only HBSE text that was based on a sample (n=16). The revised and final edition of this book was published in 1976. The title of the revised edition replaced the word *His* with *His and Her*. Although the content was toned down, the revised edition continued to be chauvinistic and fostered a Freudian cringe factor. Female social work professors were rightly hypercritical.

Regardless of what curriculum in which a student was enrolled (psychology, social work, counseling, etc.), the employment of a theoretical framework was stressed. Embracing an eclectic framework was then condemned by most professors (Maddi, 1972). Although a variety of theories were introduced, *one* theory dominated the curriculum. During the 60s to the mid-70s, the dominant theoretical theme in social work education was "ego psychology." In social work, we witnessed a paradigm shift because of Pincus and Minahan (1974). They produced what we now call the generalist model in which a variety of different and often opposing theories could fit within a generalist paradigm. From this model emerged a gradual evolving free-for-all in which theories became situationally dependent. Clinicians

would select a theory that would best solve the client's distress. For example, although ego psychology was held in high esteem, it was recognized that behaviorism was much more effective in addressing phobia problems. The concept of one theory fitting all problems began to fade away. Thus, the contemporary clinician must be skilled with a variety of theoretical frameworks.

Correspondingly, with the mindset that one theory does not fit all, clinicians and academics were put in a position to evaluate the efficacy of theories. From this emerged the concept of empirically-based practice (now called "evidence-based practice"). This movement, of course, included an emphasis on outcome measurement. Outcome measurement was not a strength of ego psychology or other branches of the Freudian framework. In the end, we have come full circle. We began with a post Freudian movement when the eclectic use of theory for intervention was dominant. The academic world responsible for training clinicians condemned eclecticism. From there, we moved to a position that every student needed to be an expert with one interventive theory. We see the emergence of the notion that clinicians should be competent in the application of a wide variety of theories. Are we are beginning to see the re-emergence of eclecticism? The original meaning of eclecticism was pulling a variety of concepts (not necessarily related) from different theories and applying them as a unified whole to a clinical intervention. Today, eclecticism includes mastery of multiple theories and employing one when evidence-based practice demonstrates the theory's power to direct a clinically defined outcome

The Link to Freudian theory

Acknowledging that theories evolve is critically important for clinical social workers to accept. The theoretical constructs that were learned at the university often become out of favor or even discredited during clinical experience. Here, we see the devolution of Freudian theory. Within our intensive library search, we uncovered 1,057 books that criticize Freudian theory. These criticisms most commonly fit within three categories which include:

- Unscientific Methodology
- Overemphasis on Sexuality
- Gender Bias

Among these three categories, the "overemphasis on sexuality" dominates critiques of the overall Freudian theoretical framework.

Perhaps the most cringeworthy sexual concept within Freud's repertoire is "penis envy." In fact, after two years of study (Marson & Dovyak, 2023), we have concluded that penis envy is the most offensive, and potentially harmful, therapeutic concept among Freud's work. We must preface any discussion of penis envy by stating that Freud never addressed this issue without also including the parallel concept "castration anxiety." Our qualitative analysis demonstrates that Freud placed *less influence* on penis envy then his followers. Originally, penis envy was considered a problematic mental state that inhabits the psyche of all females. According to the theory, women feel incomplete, anxious and cheated as a result of not having a penis.

In the larger world, and still in some Western cultures, the concept of penis envy within psychoanalytic therapy strangely persists (Marson & Dovyak, 2023). It is hard to now imagine the use of penis envy as a perspective of dysfunction within psychoanalytic therapy. Within a therapeutic session, does a premise of penis envy suggest to a female client a cause for even greater mental distress? Our search of the literature finds no answer to this empirical question. And if the dynamic of penis envy was used within psychotherapy and incited emotional regression within a female client, would its application be unethical as in – "do no harm"? This debate should be subject to a 'flat-earth' screening.

The stronger elements of Freud's theories attempt to map this metaphoric algorithm that is the language of the unconscious. In the confines of psychoanalysis, we are challenged to scientifically subject our clients to the collection of 'data in disguise'. The clinician learns how to translate the meaning of the unconscious narrative that reveal conflicts of motives and behavior. We have spent days assessing various experimental designs that

would satisfy the rigors of a scientific review board (IRB) in producing an evidence-based outcome. We are confident that *none* of our ideas would pass the standards for any fully functioning IRB. What has become transparent is that a macro therapeutic insight, filtered with a retrospective report, can describe a valid or invalid outcome that is grounded in sociological context, i.e. there was a time when 'penis envy' did accurately reveal a cultural power dynamic capable of perpetuating a latent consciousness.

Although Freud's *psychosexual stages* of development have been harshly criticized over the past decades (Ogden & Ogden, 2013), these theoretical concepts are not directly applied within the therapeutic session (Dendy, 2010; Knight, 2017; Guignard, 2023). Freud's concepts of psychosexual development provide a framework of understanding human behavior, whereas penis envy is a catalyst for dialog between a therapist and a female client. Within Freud's theoretical repertoire, penis envy is a more serious ethical issue when compared to his psychosexual stages of development. Should Freud's theory be totally rejected because of theoretical concepts such as penis envy and psychosexual stages of development?

Alternative Vision of Freudian Theory

The question to ask is, "how prevalent is Freudian theory used within clinical intervention?" In an intensive library review of journals, we uncovered journals that are exclusively Freudian (see Table 1 on next page: from Marson & Dovyak, 2023).

In reviewing these journal titles, two immediate conclusions can be drawn. First, an extraordinarily unexpected number of journals exist whose primary mission focuses on Freudian theory. Second, to compare the popularity of Freudian theory with another theory, we sought a list of journals that exclusively deal with behaviorism. Although behaviorism is held in high esteem as an interventive strategy, it fails to generate the interest in as many journals as we find with Freudian theory.

Currently Published	*Psychoanalytic Review*
American Journal of Psychoanalysis	*Psychoanalytic Social Work*
Analysis (Australian Centre for Psychoanalysis)	*Psychoanalytic Study of the Child*
Cadernos de Psicanálise - SPCRJ	*Psychodynamic Practice*
Canadian Journal of Psychoanalysis	*Revista Brasileira de Psicanálise*
European Journal of Psychoanalysis	*Revista Chilena de Psicoanálisis*
International Forum of Psychoanalysis	*Revista de Psicanálise da Sociedade Psicanalítica de Porto Alegre*
International Journal of Psychoanalysis	*Revista de Psicoanálisis de La Asociación Psicoanalítica de Madrid*
International Journal of Psychoanalysis and Education	*Revue Française de Psychanalyse*
International Journal of Psychoanalytic Self Psychology	*Romanian Journal of Psychoanalysis*
International Review of Psychoanalysis	*Scandinavian Psychoanalytic Review*
Issues in Psychoanalytic Psychology	*Tempo Psicanalítico*
Jahrbuch Der Psychoanalyse	*Zeitschrift Für Psychoanalytische Theorie Und Praxis*
Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry	
Journal of the American Psychoanalytic Association	**No Longer Published**
Language and Psychoanalysis	*Analytic Psychotherapy & Psychopathology*
Ma'arag: Israeli Journal of Psychoanalysis	*Annual of Psychoanalysis*
Psychanalyse et Psychopathologie Freudiennes	*Bulletin of the Anna Freud Centre*
Psyche: Zeitschrift Für Psychoanalyse Und Ihre Anwendungen	*Gender & Psychoanalysis*
Psychoanalysis (Seoul)	*Issues in Ego Psychology*
Psychoanalysis and Psychotherapy	*Journal of a Psychoanalysis*
Psychoanalysis Self and Context	*Journal of Clinical Psychoanalysis*
Psychoanalysis, Culture and Society	*Modern Psychoanalysis*
Psychoanalytic Dialogues	*Psychanalyse à l'Université*
Psychoanalytic Inquiry	*Psychoanalysis*
Psychoanalytic Psychology	*Psychology of Consciousness: Theory, Research, and Practice*
Psychoanalytic Quarterly	*Topique: Revue Freudienne*

Table 1: Freudian Journals

Two characteristics facilitate the employment of Freudian theory. A number of Freudian theoretical concepts have bled into a wide variety of mental health interventions. Within our extensive literature review, we uncovered specific Freudian clinical concepts that have become an integral part of professional conversation. The concepts are (alphabetical order):

- Countertransference
- Defense mechanisms
- Ego
- Ego strength (not in Oxford Dictionary of the English Language)
- Freudian slip
- Libido
- Preconscious
- Subconscious

- Talk therapy as nonmedical
- Therapeutic confidentiality
- Transference

Two terms require additional comments:

1. Within the adjudication process and documentation, clinical social workers who violate boundary issues (particularly of a sexual nature) are described by using the Freudian terms transference and countertransference. Within the English language, there are ***no*** other words that captured the essence of meaning found within these two Freudian concepts (as generated from artificial intelligence).
2. Although talk therapy/counseling has existed since the early 1800s, we do not see literature that stresses the importance of confidentiality until Freud's writing. Although women were considered the property of men during Freud's lifetime, he did not disclose information derived from therapeutic sessions to clients' husbands. Freud was uncharacteristic for his time. He treated the female "patient" as a person and not as property of her husband and/or father.

Without a doubt, traditional Freudian concepts have found their way into alternative theoretical frameworks.

We note that many Freudian concepts have entered the realm of "public domain." The best example can be found in the work of Winick (1997). As a psychologist and lawyer, Winick offers a comprehensive assessment of a wide range of theories within the context of therapeutic intervention for involuntary clients who have been ordered by the court to receive therapy. The book includes an assessment of psychotherapy, behavioralist interventions, psychotropic medications, electroconvulsive therapy, electronics stimulation of the brain, and psychosurgery. The primary audiences for this book included lawyers and judges. The book review (Marson, 2000) notes:

> …in surveying the major issues and tenants of behavioral therapy, he employs psychoanalytic language. I found myself chuckling as I read this chapter, but I am well aware that psychoanalytic jargon has entered street language. In short, the author explains behaviorism by employing a psychoanalytic framework. Although mental health professionals will see Winick's explanation as awkward, it might be the most efficient summary for lawyers and judges.

For those professionals who are only *slightly* familiar with therapeutic intervention, Freudian concepts are public domain material. Even those without the educational background have a fundamental understanding of Freud's psychoanalytic theory. Jargon from the era of Woody Allen movies is clearly recognizable as Freudian. Freudian concepts are fully integrated into the language of the people. Freudian concepts persist as part of the public domain.

The most powerful example of Freudian concepts moving into the public domain include transference and countertransference. The notion of Electra and Oedipal complexes were the catalysts for the existence of transference and countertransference. Transference and countertransference are no longer linked to the Freudian concepts but retain their value in understanding, categorizing and intervening in clinical intervention. As stated earlier, these Freudian concepts continued to be frequently used today. In a cursory review of literature, we discovered 35,150 citations in which transference and countertransference were the central themes. These two concepts alone continue to have a powerful influence within the minds of the contemporary clinician.

Baby Out With The Bathwater?

In a monumental and controversial move, Freud was the first professional to demedicalize psychotherapy. He strongly contended that a medical degree *was not* required to be a competent psychotherapist. His position was unprecedented and was coupled with the medical community's expansive opposition. His position was also the catalyst for the *evolution* of "psychiatric

social work." Historical records demonstrate that psychiatric social workers were the first non-physicians to qualify as psychotherapists (Ruffalo, 2022). It is clear that if the medical community, during Freud's time, were more rigorous and vigilant gatekeepers, clinical social work would *not* exist.

Few people will disagree with the statement that Freudian theory includes some offensive and theoretically weak concepts. The centerpiece of our discontent is the concept of "penis envy" and Freud's traditional psychosexual stages of development. That being said, there is another side to Freudian theory. Freudian concepts are deeply embedded into the collective consciousness of Western civilization. Freudian concepts are deeply embedded into everyday life and are part of the public domain. In other words, Freud is not getting acknowledged for his contribution.

Freudian theory is a victim of "stigmatization." The label of "Freudian Theory" has become more disreputable than most of the ideas housed within Freudian Theory. For example, the notion of "socialism" is condemned by a large number of retired Americans, but Social Security is embraced. This Social Security system is a product of socialism (Marson, 2019). In fact, we are at the point where many retirees vigorously deny that Social Security is a product of socialism. Social Security is accepted but socialism is *not*. This vision of Social Security (not being a dimension of socialism) is logically untenable. In many sectors of the mental health professional community, Freudian theory is condemned but the central concepts of Freudian theory are embraced. Just like socialism.

In our review of *current* clinical social work practice, we have uncovered a pattern in which Freudian concepts are routinely employed within intervention. The question, "is it unethical to employ Freudian theory in clinical social work?" might be a misnomer. Perhaps a more appropriate question would be, "is it ethical to employ Freudian concepts without acknowledging credit?" Ironically, we see patterns among younger clinical social workers who lack adequate general understanding of Freudian theory. They don't seem to be aware that many of the concepts they employ within their intervention strategies emerged from Freudian theory. Freudian concepts have been usurped and are now part of the public domain. When we think about

it, the lack of acknowledgement and infiltration within the public domain, is the highest compliment one can attribute to Freud.

We are interested in your comments, email them to journal@ifsw.org.

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Book Review 1

Gerhard, A., McLean, S. & St. Denis, V. (2022). White benevolence: Racism and colonial violence in the helping professions. Columbia University Press: Fernwood Publishing.

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Reviewed by Stephen M. Marson, Ph.D.
Editor IJSWVE

White Benevolence: Racism and Colonial Violence in the Helping Professions is an edited volume with an emphasis identifying the historical foundation for current environments of social inequality and social injustice. The 21 authors had a shared vision. All had a desire to enhance critical race theory, antiracism theory, anticolonialism theory and whiteness studies. Although the emphasis is placed on Canadian history and its current environment, the insights offered are applicable anywhere within our global society. In a united format, the authors envision white benevolence as a form of "paternalistic racism." I find their perspective refreshing and creative which is best illustrated by citing the chapter titles:

- Living my Family Through Colonialism
- Toxic Encounters: What's Whiteness Doing in a Nice Field Like Education
- How Indigenous Specific Racism is Coached into Health Systems
- Within this Architecture of Oppression, We are a Vibrant Community: Indigenous Prairie Prisoner Organizing During COVID-19

- Tracing the Harmful Patterns of White Settler Womanhood
- Policing Indigenous Students: The School Prison Nexus on the Canadian Prairies
- Stories We Tell: Indigenous Women and Girls' Narratives on Police Violence
- Colten Boushie and the Deadly Articulations of Settler Colonialism: The Origins and Consequences of Racist Discourse
- What Can "Settler of Color" Teach Us? A Conversation of the Perplexities and Complexities of Decolonization in White Universities
- I am a Settler: Considering Dominance Through Racial Constructs and Land Relationships
- Unmasking the Whiteness of Nursing
- The Whiteness of Medicine
- The Circle of Rocks: Cannibal Culture, Kinship and Indigenous Youth in the Saskatchewan Public School System
- Permission to Escape White Entitlement in Antiracism and Anticolonialism
- An Interview with Dr Alex Wilson: Queering the Mainstream

Each chapter constitutes a comprehensive review of literature addressing the topic found in each individual title. Taken as a whole, the book offers a synthesis of a massive amount of high-quality data and theoretical analysis to perform as a catalyst to comprehend *paternalistic racism*. Although the editors of the book do not articulate the audience for which this volume has been written, it is clear that they intended to attract Canadian social workers and others who have a concern for social equality.

Taken either as a whole or each individual chapter, the result is that the reader will be propelled to reflect on one's past experiences and reframe life events, which provides a chilling revaluation of one's own life. As a white male social worker, I was propelled to rethink my experiences within the

context of what I've read. The focus of my thoughts evolved around what Americans refer to as "white privilege." I never thought of myself as privileged and certainly never felt *privileged*. My life was filled with battles (mostly intellectual) with other white men. Such overt conflicts and intimidation does not feel like a privileged experience. However, within the light found within this book, I have drawn a different conclusion, which forced me to reconceptualize my understanding of white privilege. The book made me rethink that the experience of white privilege should not be thought of as a privilege at all: It should be the norm. If privilege is the ability to experience life fully in the same way that everyone else does, it is, in fact, the manner in which all people are entitled to experience. White privilege, as a concept of oppression, clearly, empirically exists. Those who do not experience it are experiencing *social injustice*. What, in fact, we call white privilege is actually the *normal* way in which everyone should experience their life events. Everything else is social injustice!

Typically, two major concerns are salient in assessing an edited book: First, each of the chapters within this book provide "stand alone" perspectives. That is, one could read a single chapter without the need to read the entire book. This phenomenon is characteristic of most edited volumes. For the instruction of social work students, the independence of the chapters can be considered problematic in providing instruction. Although this is a worthy book for college assignments, professors need a methodology to tie the chapters together. I have a recommendation. As part of instruction, professors can employ "standpoint theory" (Swigonski, 1994) as a tool to unify the insightful chapters within this book. When a professor uses a theoretical framework to tie these chapters together, the result is an extraordinarily powerful learning experience. Although Swigonski's work is old, good theory traverses historical circumstances and continues to offer profound insight.

Second, for students who purchased the book for an assignment or others who are using the book for research purposes, it is absolutely essential that the index is thorough and even handedly addresses all key concepts. The completion of an index for an edited book is a herculean task.

After a thorough assessment, I have concluded that the index will be helpful for both students and researchers who need to return to material that they read. If readers are forgetful like me, this index is an absolute necessity.

In the end, I recommend this book without reservations. *White Benevolence: Racism and Colonial Violence in the Helping Professions* should be adopted in every academic library that includes social work or human services curricula. Certainly, I see the book as critically important for Canadian students, but I can understand how important the readings would be for those studying social work in the northwest United States. It is a worthy read that will have an impact on personal insight and, most importantly, everyday social work practice.

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Book Review 2

Peterie, M. (Ed.). (2024). Immigration detention and social harm: The collateral impacts of migrant incarceration. Routledge.

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Reviewed by LeAnn Howell, EdD, MSSW, LSW
Brescia University

Immigration Detention and Social Harm: The Collateral Impacts of Migrant Incarceration is a compilation of works dedicated to exploring the physical, emotional, and economic harm brought about by the incarceration/detention of migrants, the separation of families, the isolation of individuals, and the effects on those "working" within the system. The work is edited by Michelle Peterie, an accomplished researcher on the consequences of social policy on individuals and collective societies as a whole. Peterie is a Research Fellow in Sociology at the Sydney Center for Healthy Societies and School of Social and Political Sciences at the University of Sydney.

This collection offers comprehensive insights from esteemed contributors in the world of migrant incarceration/detention within the contexts of personal experiences, geographies, social positioning, gender, economics, and policy. Multiple perspectives are offered to include the impacts of migrant detention in terms of human costs and societal consequences, as well as perspectives from the persons detained, their families, communities, and those working within the system. The book culminates not only with persuasive evidence supporting the need to end migrant incarceration, but with emphasis of the lasting effects of the broad social harm caused by

systemic negligence through discrimination, oppression, and lack of transparency and access to information for those involved in migrant detainment.

These compiled works shed light on the ways in which harm is intensified for individuals whose circumstance/identities include the intersectionality of economic class, gender, race, ethnicity, spirituality, sexual identity, and age. Highlighting these intersectionalities offers the reader a better understanding of the complexities presented and the effects realized at every level of intervention. Sensitive topics are covered and may be best suited for a socially informed, mature audience. These sensitivities are most evident when considering the emotional, physical and spiritual impacts of parental incarceration on children, as well as experiences specifically encountered by women. The reader is given qualitative and quantitative insight into the lasting impacts on societal structure and disparities present in systems ranging from policy and economics to family cohesiveness and community health.

Major highlights are the qualitative accounts of individuals and organizations directly involved, which demonstrate the current negative impact of political discourse on society. The need for placing human experience as priority in decision-making and policy reformation is evident. The diversity of settings, populations, and areas of focus among the included works adds to the breadth of knowledge and information contained, which allows the reader to better understand the effects of overlapping systems of discrimination. This compilation is highly recommended reading for anyone with interest in immigration reform, immigration law, prison reform, or human rights in general. With each section made up of published research from a diverse group of scholars, perspectives, and contexts, it is ideal for assigned readings in classes such as criminal justice, diversity, human rights, social welfare policy, gender studies and more.

If any weakness is present in this compilation, it would be the need for recommendations and strategies for policy reform, or the inclusion of case studies where specific interventions were evaluated showing positive

outcomes or highlighting the need for further research in precise, definable areas.

Book Review 3

Reamer, F. G. (2024). Social work values and ethics (6th ed.). Columbia University Press.

DOI: 10.55521/10-021-214

Reviewed by: Peggy Proudfoot Harman, MSW, Ph.D., LICSW, LISW-S
Marshall University, Department of Social Work.

Chances are, if you have been or are presently a practicing social worker in any sized system that encompasses various roles and tasks, you have encountered at least one ethical dilemma. Perhaps in your role as a child welfare social worker, you have been working with a particular family who is trying to regain custody of their young children. The parents have been steadily improving their parenting skills and have shown tremendous fortitude in following the treatment plan that you both carefully laid out. They are close to regaining custody of the children when you receive an anonymous call claiming that the father of the children was accused over 10 years ago of selling child pornography in another state. You investigate the charges and find that although he was not convicted, he had failed to report these charges during the family assessment. What should you do? How should you proceed after you find that the allegation is true? Reamer provides a process for that.

In your role as a college professor in a leadership position, you have been assisting a trusted colleague with promotion and tenure, as well as providing mentorship on leadership functions with the hope that the colleague will use these skills to eventually lead your department as program

director. You are taken aback when you learn that this faculty member has been making comments about you to others in your department as well as to administrators stating that you need to retire because you are old and have memory issues. What should you do? Reamer has a process for that.

Reamer's latest issue of *Social Work Values and Ethics* (6th ed.) is an attestation to his mastery of laying the foundation for identifying, categorizing, and processing the most simplistic to the most outrageous ethical dilemmas faced by contemporary social workers in every role and every sized system. This work is thoroughly thought out, providing an overview of ethical concepts and theories expertly woven in with the ever-changing history of society, and subsequent ethical challenges created from the dynamic impact of societal and environmental forces that influence clients to seek social work services.

The contents of his present work on *Social Work Values and Ethics* (6th ed.) not only reflects Dr. Reamer's academic background in criminology, social science, and social work, but illustrates the depth of his knowledge on the subject matter, having authored over 150 publications (ResearchGate, 2024). Seven of these publications are noted as being "significant publications" to the annals of social work ethics. It is fitting that Dr. Reamer's biography as a "NASW Pioneer" is discussed on the NASW Foundation site, because he is fundamental to the foundation of the NASW Code of Ethics, having among other accolades "chaired the task force that wrote the current *Code of Ethics* implemented by NASW and remains the "chair of the NASW Technology Standards Task Force and continues to serve on the Code of Ethics Revisions Task Force." The site notes that some "Pioneers" are famous in various realms, and Dr. Reamer is certainly one of those rare commodities that is famous among a variety of professionals, having served on committees that have shaped ethical standards for business, bioethics and many aspects of human services, including juvenile justice (National Association of Social Workers Foundation, 2021).

With such a robust history in ethics, education, and reform, it is not surprising that Reamer's current work provides the reader with a history of social work values and ethics, weaving historical, philosophical discourses on

values from Kant (pp. 80, 82, 201) to Levy (p. 39), all the while expertly incorporating real-world case scenarios that highlight the difficulties regularly faced by social work specialists at all levels of practice.

Using typologies of values, specifically the use of "Core Values" (p. 21) to begin the discourse on solving ethical dilemmas, Reamer reminds us that when facing ethical issues, we need to first "know thy self," taking note of the various values orientations that guide our daily interactions and that should be considered in the framework of solving ethical quandaries.

Of particular interest is Reamer's discussion about the need for social workers to be clear about professional values because judgements in practice are based on clarity and understanding of values. Reamer maintains that "there is a need to convert conceptually based values that are usually written in abstract language into concrete guidelines for daily practice" (p. 53).

The text is case-driven, providing real-world examples that illustrate ethical dilemmas and the application of ethical principles in various scenarios. It covers a wide range of topics, including boundaries, dual relationships, documentation practices, and risk management, making it a thorough resource for both students and experienced practitioners. Reamer emphasizes the importance of cultural awareness and sensitivity in social work practice, addressing the need for antiracist practices and understanding diverse perspectives.

The balance between theoretical frameworks and practical applications makes the book accessible and useful for understanding the complexities of social work ethics. It addresses the rise of technology in service delivery, such as the ethical implications of using online platforms and social media, and related issues of confidentiality and informed consent.

Using the latest *NASW Code of Ethics*, Reamer helps us better understand issues facing many practitioners and provides a framework for solving ethical issues of all kinds. By incorporating history, philosophy, and practice situations, Dr. Reamer has fashioned a very educational and practical book which should be used in all social work ethics courses.

Academics and practitioners have regarded Reamer's expertise in ethics as the foremost primer guiding decision making when faced with ethical dilemmas. The case scenarios provide excellent situations to utilize the decision-making framework helping students and professionals alike to consider their behavior in practice.

Reamer discusses a variety of ethical codes related to various professions and updates to the *NASW Code of Ethics*, ensuring that readers are aware of current standards and practices. An important feature is the incorporation of elements from the legal realm that provide "five distinct sets of requirements and guidelines that are relevant to many ethical dilemmas" (p. 98). Often, practicing social workers do not understand how to work through ethical issues when their professional code conflicts with legal standards, and these guidelines remind us that there is no black and white when it comes to solving ethical dilemmas. Professional social workers must be knowledgeable and proficient in many realms, including law.

It is difficult to discuss any weaknesses of this book. The author is the foremost expert on social work values and ethics and shows his expertise throughout the book. For those of us who have taught in the academy, Frederic Reamer is an icon whose name we have heard numerous times, and whose works were a requirement in our education. In this work, Reamer reminds us to engage in a "continuous cycle of self-reflection about the process" we use to make decisions and act on those decisions. Reamer notes that reflective practitioners are able to recognize ethical issues and are able to critically think them through, adjusting "decision making and risk-management protocols" (p. 262).

All practicing social workers and students must read this book and keep it as a reference that will be utilized on a regular basis at work and in class.

References

National Association of Social Workers Foundation. (2021). *NASW Pioneers Biography Index*. *https://www.naswfoundation.org/Our-Work/NASW-Social-Work-Pioneers/NASW-Social-Workers-Pioneers-Bio-Index/id/466*.

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