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

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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	Competency	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

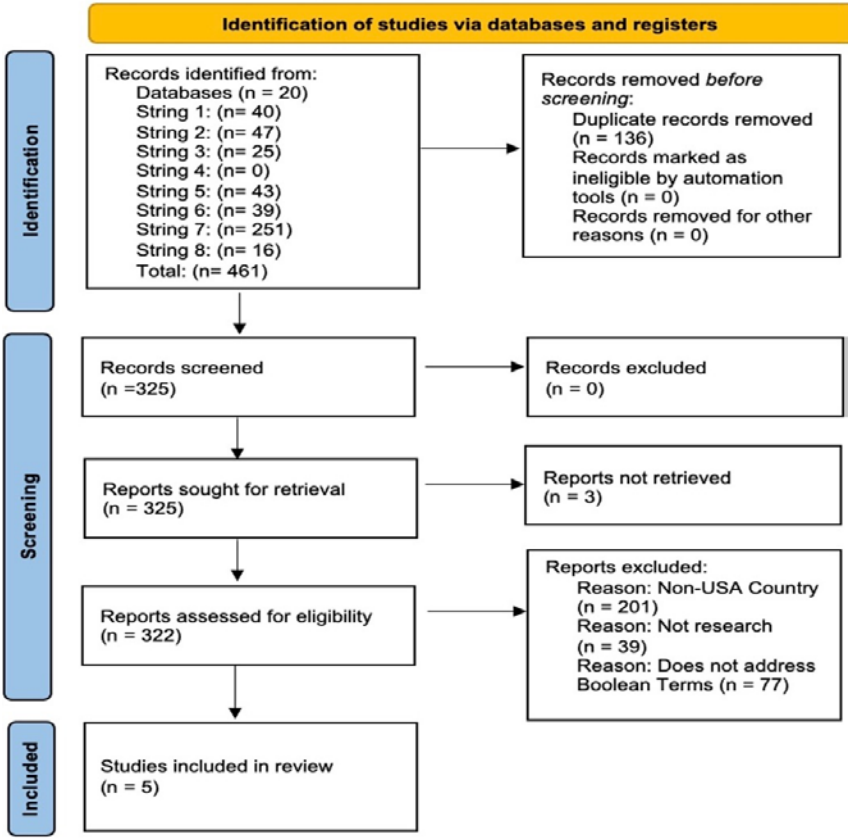

Figure 1: Inclusionary Criteria

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**