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Is coercion ever beneficent? Public health ethics in early intervention and prevention for mental health

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Early intervention in mental health seeks to improve the wellbeing of as many people as possible, by intervening at an early stage in the onset of illness, or by taking preventative action in 'at risk' populations. The paradigm is rhetorically powerful, and it is easy to talk in terms of it helping to deliver rights to health and realise social justice. However, in spite – or perhaps because – of the apparently unarguable desirability of such goals, it is harder to discuss rights to dissent. In this respect the risk of coercion is an issue that should be discussed, especially because of the stigmatizing effect that the labelling associated with early intervention may have in mental health contexts. Here we explore this issue, with a particular focus on its practical and ethical implications in relation to UK policy for treating Attention Deficit Hyperactivity Disorder and mild Conduct Disorder in young people.

1. Introduction

Half of all people who develop mental disorders experience their first symptoms by the age of 14%, and 75% have had their first symptom by their mid-20s (Department of Health, 2017; Khan, Parsonage, & Stubbs, 2015). According to the latest published national study on young people's mental health in UK, 1 out of 10 children aged 5–16 has a diagnosable problem (Mental Health Taskforce, 2016). Yet most of them, 60%e70%, do not receive appropriate and timely interventions (Department of Health, 2015). It follows that society should take child mental health very seriously and should consider strategies for prevention and early intervention. In this context, prevention involves identifying individuals at risk of developing a disorder and taking action before the condition becomes manifest. Early intervention includes both early detection of disorders, and the use of

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psychosocial and pharmacological interventions for the phase-specific treatment of the earlier stages of illness (McGorry & Pelosi, 2008).

We will begin by showing that within UK government policy, the case for prevention and early intervention in mental health relies on the existence of a virtuous circle between societal and individual interests, wherein the good of the individual and the good of society are perfectly aligned. We call for critical scrutiny of this alleged virtuous circle, by raising the concern that young people may be coerced to undergo preventative interventions for the good of society, and in the process their individual goals and values may be undermined, with their capacity for authentic agency unjustly constrained.

We will focus on two disorders commonly diagnosed in childhood, attention deficit hyperactivity disorder (ADHD) and conduct disorder (CD), to illustrate how issues of coercion may arise in proposals for managing challenging behaviour towards the realisation of the apparently virtuous circle of individual and collective goods. To do this we will use a theoretical examination of the concept of coercion and apply it to policy proposals for management of these conditions. We will conclude by drawing on insights from critiques of the public health strategy of nudging to show how the moral status of proposals for managing the conditions may differ depending on the socio-economic positioning of those to whom the proposals are made.

2. Early intervention: a moral and an economic case

Early intervention and prevention are increasingly promoted by governments both in the UK and abroad (Mortimer, McKeown, & Singh, 2018). In advocating for early intervention, typically two arguments are proposed - we call these 'the moral case' and 'the economic case'.

The moral case turns on the duty of the state to promote and safeguard the wellbeing of minors. The claim is that poor mental health adversely affects young people's emotional and social development as well as their academic and job performance, both now and in later life. It is argued that the state should intervene to prevent this, not least because young people are vulnerable and cannot always protect themselves. Monitoring young people's mental health is needed not just by reference to individual wellbeing but as a requirement of justice, since '*children with a persistent mental health problems face unequal chances in life*' (Department of Health, 2017, p. 6), or fewer opportunities than their peers. Thus, it appears that UK policy provides a twofold justification to make the moral case, focussing both on the best interests of individual children, and on social justice.

The moral case is supported by an economic argument that takes into account the broader societal costs of mental health issues starting in early life. This is generally discussed in terms of cost to the taxpayer, and policy documents often focus specifically on the overall lifetime economic costs of behavioural problems, which, if sufficiently severe and persistent, lead to the diagnosis of mental health conditions such as ADHD or CD (Department of Health, 2015). It is estimated that ADHD costs society £100,000 per case; two-thirds of the cost takes the form of additional public expenditure on education and health care, with the remainder being reflected in reduced earnings (Khong, 2014). Costs may also be incurred by the criminal justice system, since individuals with conditions like CD often become involved in crime and antisocial behaviour. This means that young people who develop CD at a young age cost the public sector ten times more by the age of 28 than other children (Scott, Knapp, Henderson, & Maughan, 2001).

The putative virtuous circle asserted between the moral case and the economic case suggests that individuals' interests are necessarily aligned with broader public health and economic interests (Department of Health, 2017). If individual mental health and societal interests *are* seen to coincide, the moral case and the economic case can be used to emphasize the importance of early intervention and prevention of mental issues in minors:

> *Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change […] Prevention and early intervention are not only desirable but cost-effective*
>
> (Department of Health, 2015, **p. 23**).

> *The growing interest in early intervention as a policy issue reflects the widespread recognition that it is better to identify problems early and intervene effectively to prevent their escalation than to respond only when the difficulty has become so acute as to demand action. It is better for the individuals concerned, their families and society more broadly; it avoids a lot of personal suffering, reduces social problems and generally, it costs less than remedial action*
>
> (Davies & Bromley-Derry, 2010, **p. 4**).

However, a persistent feature of public health discourse is the recognition that individual and societal interests often conflict. Since public health seeks to achieve gains at the population level, in making utility calculations about what will produce the greatest net or aggregate benefit it is sometimes necessary to sacrifice individuals' interests. In other words, given that wishes, plans, desires, goals, and values are plural, some will inevitably conflict and so strategies deemed beneficial at the societal level will not always align with what particular persons consider good for them *as individuals*. Public health strategies are primarily justified by their utility, so the interests of a minority can be subordinated if doing so yields aggregate benefits at the population level. Therefore, despite the apparent confluence often posited between individual and societal interests with respect to behaviour deemed challenging or in need of intervention, we argue that we should not unreflectively assume that such interests will be mutually consistent.

In light of these considerations, we contend that there are two main reasons to be concerned about policy guidelines that use the kind of language and argument described and demonstrated above. First, they appear unarguable because few would deny that the state has a responsibility to promote child welfare and protect minors from harm where possible. The mental health of minors is a rightly emotive and important issue for society. Nevertheless, arguments for early intervention often involve the translation of complex scientific data and ethical arguments into policy rhetoric that eschews ambiguity (Mortimer et al., 2018) and we should thus be prepared to critically assess policy rhetoric that appears unarguable.

Second, the attempt to demonstrate individual and societal interests as mutually complementary raises the question of in whose interests interventions are designed. We are concerned that the rhetoric of support for people in need may mask the promotion of practices or interventions that seek to shape individuals to display certain traits and behavioural characteristics deemed convenient for society as a whole but according to an excessively idealistic view of the good citizen. In this way there is a risk that interventions will take the form of surveillance, targeting individuals deemed risky to treat behaviour that the state considers deviant. This is concerning not only if the traits and behaviours of the good citizen are imposed via interventions that are themselves ethically controversial - for example, if treatment is likely to stigmatise a given individual (Moldavsky & Sayal, 2013).

Further, interventions are also ethically concerning if the traits and behaviours that the intervention seeks to promote do not align with the kind of character that some young people themselves endeavour to cultivate.

Or conversely, if the defiant traits or those considered deviant that intervention seeks to change are in fact valued by the individual as part of her identity and useful in her life (Potter, 2016). Of course, in saying this we do not claim that young people should be allowed to pursue *any* life they choose; it is right, for example, that the state should intervene to prevent individuals from cultivating cruelty and aggression in order to pursue a life of crime.

Rather, we argue that the vision of the good citizen inherent in state early intervention should not be so narrow as to limit the ambitions of individuals who might pursue visions of the good life that are not defined by economic prosperity, academic success, or raising a family, for example.

It is important to note that we do not raise these concerns to advance a straightforward libertarian case for the state to stay out of individuals' private lives and choices; indeed, we accept and endorse the need to promote, support, and improve the mental health of minors. However, it is important to scrutinize the arguments upon which preventative measures are based, since such arguments carry the risk of endorsing policies that are unjustly coercive, and which may ultimately harm those minors they purport to protect.

Before exploring the nature of coercion in more detail, we will outline the two conditions we are considering - ADHD and CD. We introduce each condition before considering some of the forms that early intervention and prevention can take in the context of these two disorders.

3. The two conditions

ADHD and CD are among *'the most common mental health conditions affecting children and adolescents'* (Khan et al., 2015, p. 4). Studies suggest that the worldwide prevalence of childhood ADHD ranges between 3% and 7%; ADHD is more commonly diagnosed in boys than in girls, with a male-to-female ratio of 3:1 in population-based studies and between 5:1 to 9:1 in clinical samples (Skogli, Teicher, Andersen, Hovik, & Øie, 2013). The proportion of children with CD increases with age (Khan et al., 2015), and – like ADHD – they are more common in boys than girls. It is estimated that 7% of boys and 3% of girls aged 5–10 years are diagnosed CD; amongst children aged 11–16 years, the proportion rises to 8% of boys and 5% of girls (NHS, 2013).

ADHD has an estimated comorbidity rate of approximately 16%e20% with CD, although some consider ADHD to be a developmental precursor to CD as well as to Oppositional Defiant Disorder (Beauchaine, Hinshaw, & Pang, 2010; Biederman et al., 2008; Villodas, Pfiffner, & McBurnett, 2012); in this sense, prevention of one disorder may also prevent the other.

Given the apparent prevalence of ADHD and CD in the UK and the serious implications that these conditions have for individuals' wellbeing and life opportunities (Khan et al., 2015; Khong, 2014), many have advocated early identification of at-risk children and families as a method of prevention, as well as timely support for individuals exhibiting symptoms in the early stages of illness. This advocacy spans policy makers, academic researchers, and voices from the third sector. At the same time, the status of ADHD in particular as a genuine psychiatric disorder is widely contested (Rafalovich, 2004). Both ADHD and CD exist on a spectrum from mild to severe behaviours. In the context of ADHD, critics argue that too many children are diagnosed and treated for behaviours at the relatively milder end, due to contextual factors such as inadequacy of educational resources; biases against children who are poor and/or ethnic minorities; performance pressures on children in high-performing schools, and so forth; however these same factors can also contribute to under-identification and undertreatment in various contexts (Merten, Cwik, Margraf, & Schneider, 2017; Singh, Filipe, Bard, Bergey, & Baker, 2013). Due to these and other complexities related to identification of ADHD and CD, epidemiological statistics we and others cite should be viewed with a critical eye (Singh, 2018).

3.1. Attention Deficit Hyperactivity Disorder

ADHD is diagnosed when an individual displays both inattentive and hyperactive behaviour, and when this interferes with normal functioning in multiple domains of life (i.e. at home, at school, during social activities). DSM-V states that several symptoms must have been present before the child reached age 12 (APA, 2013). Examples of hyperactive behaviour include: fidgeting, failure to remain seated when sitting down is required, and an inability to wait one's turn. Examples of inattentive behaviour include: inability to focus on a task, often

failing to check one's work for mistakes, being easily distracted and regularly forgetting or losing items necessary for daily activities.

3.2. Conduct Disorder

CD is diagnosed when an individual displays a persistent and repetitive pattern of behaviour that *'violates the rights of others' and which 'breaches age-appropriate social norms'* (American Psychiatric Association [APA], 2013, p. 1). In practice, this often leads to breaking of school or home rules, or law breaking and criminal activity. CD involves a range of anti-social behaviours varying in seriousness, from school truancy and defiant behaviour to arson and sexual assault.[1] When diagnosing CD, DSM-V states that one must specify whether the individual also displays '*limited prosocial emotions*'; in order to fulfil this criteria, the individual must have displayed two of the following over the past 12 months across multiple environments: lack of remorse or guilt; lack of empathy; lack of concern about one's own performance; shallow or deficient effect.

4. What forms do early intervention and prevention take?

Similar preventative interventions are recommended in the case of ADHD and CD. Some focus on changing the environment around the child, by targeting the parents of children who are at risk of developing the conditions. A notable example is the Family Nurse Partnership in England, which provides first-time young parents with regular visits from early pregnancy to when the child is two. The aim is to identify mothers experiencing social disadvantage, to support them to have a healthy pregnancy and to promote their children's development. The virtuous circle discussed above can be seen in the vision of Family Nurse Partnership, as stated on its website, that *'every baby, child and young parent can thrive, fulfil their aspirations and contribute to society* (Family Nurse Partnership, 2018), clearly implying a correlation between good health and good citizenship. Here, 'health' refers both to physical and mental health, and the Family Nurse Partnership explicitly seeks to reduce crime and antisocial behaviour by minimising risk factors that may contribute to the development of mental health conditions like ADHD and CD in young people (Olds, 2007).

Some intervention programmes focus on parents whose child has already been diagnosed with ADHD or CD, or who is beginning to display difficult behaviour which might suggest he is at risk of developing these conditions.[2] In this case, parents may be taught discipline strategies, learning how to appropriately praise and reward good behaviour, as well as practicing techniques like distraction or time-out for bad behaviour (Jones, Daley, Hutchings, Bywater, & Eames, 2008; Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001). Similar interventions may take place in schools, supporting teachers to adapt the classroom environment or learning outcomes so as to meet the specific needs of children with ADHD or CD (DuPaul & Stoner, 2014).

Finally, there are some pharmacological and psychosocial interventions that target children or young people themselves. Drug treatments for ADHD are common, and the most widely used is Methylphenidate, a stimulant drug that works by increasing activity in the brain, particularly in areas that play a part in controlling attention and behaviour (NHS, 2018). Indeed, a recent systematic review and meta-analysis of the relevant data has found

1 Here we will focus on the lower end of the spectrum, because these milder behaviours are more comparable to normal - albeit 'naughty' - childhood behaviour. In the second part of this chapter we consider the possibility that preventative action may coerce young people into accepting the values and ideals of society rather than allowing them to develop freely. While such an argument may be persuasive in the context of mild behaviours like inattentiveness or school truancy, it does not apply to cases of extremely violent or aggressive behaviour. It is not appropriate to argue that we should protect the rights of youth to commit violent crimes, since such behaviours clearly violate the rights of others in ways that are severely harmful and dangerous.

2 Some of these programmes can rightly be considered 'early intervention', whereas others are more accurately termed preventative. The distinction between intervention and prevention is blurred in the context of conditions like ADHD, as we discuss further below.

methylphenidate to be the most effective drug treatment for ADHD in young people and recommends it for severe cases of ADHD in view of the significant therapeutic benefit that it offers to affected individuals (Cortese et al., 2018).

To date there is no licenced drug specifically for the treatment of CD, though some medications have demonstrated effectiveness, mainly belonging to three classes of psychotropic drugs: mood stabilizers, neuroleptics, and stimulant (Gérardin, Cohen, Mazet, & Flament, 2002). Psychosocial interventions that target the individual child include therapies such as Cognitive Behavioural Therapy or general counselling, to promote selfesteem or good peer relationships for children. Other psychosocial interventions seek to target the environment around the child, which may be the home or school environment; such interventions often focus on parent training (Khan et al., 2015; Scott, 2008). While none of these interventions purport to cure the disorder, they may help the individual and those around them to manage symptoms. In neither the case of ADHD nor CD are medications typically used as early interventions for minors deemed at risk who do not as yet display symptoms of either condition. It is arguable, however, that treatment of children with milder bad behaviour is preventative, in the sense that it might help curtail current behavioural difficulties that could result in more severe consequences for the child which could eventually trigger more severe mental health problems.

To conclude this point, it is important to remark that preventative action is particularly difficult in the context of mental health conditions like ADHD and CD because it is hard to determine on whom preventative or early interventions should be performed. This is a consequence of the diagnostic uncertainty that characterises psychiatry in general and conditions such as these in particular (Singh & Wessely, 2015). Unlike fields of medicine in which biological markers are available, psychiatric diagnosis is based on a behavioural assessment or on the observation of behavioural symptoms (Singh & Rose, 2009). The behavioural dimension of mental health conditions is one of the reasons why defining boundaries between pathology and 'normality' as well as between psychiatric disorders is more complicated, which often means that psychiatric diagnoses refer to a wide spectrum of presentation of symptoms (Hyman, 2010). As noted, ADHD and CD share some diagnostic criteria and, since these include behaviour on a continuum with normality, it can be difficult to distinguish, for example, 'normal' inattentiveness and ADHD (Parens & Johnston, 2009). By extension, therefore, it can be argued that medications are sometimes used to treat children who do not in fact have a disorder.[3]

These epidemiological, epistemic and nosological complexities explain why in most cases we currently lack objective biological measures to identify with any degree of certainty which at-risk children will actually develop a specific mental health disorder and to what degree, given that ADHD and CD are spectrum disorders. These pose challenges for clearly identifying those individuals that early interventions should target. Thus, it is clear that while early intervention and prevention can in principle offer an important opportunity to improve the wellbeing of children, including some of the most vulnerable and disadvantaged, the reality of correctly identifying and supporting those children who really do need help in the particular case of ADHD and CD can be complex and challenging. In light of these practical hurdles to effective intervention, the virtuous circle between individual and societal interests begins to look more complex. In the next section, we will discuss whether, why, and in which cases this may be ethically problematic by critically analysing the ethics of early intervention through the lens of coercion.

3 Indeed, there are reasons to think that the effects of a drug such as methylphenidate is likely to be appealing to individuals without the condition given that it has been shown to be effective in improving concentration and attention and thus has gained popularity amongst students as a study aid or 'smart drug' for cognitive enhancement (Ragan, Bard, & Singh, 2013). A considerable literature exists on the ethics of stimulant enhancement, which falls beyond the purview of this chapter, and which we therefore do not cover here.

5. Coercion

CD and ADHD are disorders with a strong normative dimension; their diagnostic criteria include behaviour and traits considered unruly at the lower end of the spectrum, and cruel or immoral at the more severe end. The state has an interest in preventing such behaviour, particularly when an individual may commit a criminal offence; this creates a context in which the state may support coercive policies to prevent unruly behaviour in the name of public health and wider societal goods. Irrespective of whether a proposal is or is not coercive, policies that endorse the curtailment of individual liberty for the greater good are powerful, since an argument for almost anything can be made once the basis of justification is utility-driven, as is typically the case in public health.

Given this background, coercion-relevant questions arise in the case of ADHD and mild CD. In this section, we address these concerns. First, whether the putative public health benefit[4] justifies coercive interventions in minors beyond the nominal claim that we ought to support the (future) interest of the developing individual where possible. Second, how the right to refuse intervention can be protected, given that however wise we think it might be for people to act in ways that conduce to each other's well being, we should not enforce it in all cases, as this would be unacceptably intrusive. Relatedly, we consider how to protect young people's capacity to develop their own values and goals, rather than assuming they will adopt the values and goals enumerated by the state and adhere to a predetermined account of good citizenship. Towards the end of the paper we briefly refer to the literature on nudging in public health, as a way of illustrating by analogy some of the ideas that we discuss here.

Before continuing, it is important to note that because early interventions target disorders that typically begin in childhood, our reflection on coercion will focus on children and young people. Children and young people may make a particularly challenging case in discussions about coercion. It is often assumed that minors lack decision-making capacities and that they often copy adults' opinions when asked to make their own choices; this is one of the reasons why, for instance, research on minors' views and experiences is often criticised as lacking validity and reliability (Singh, 2016). If this is the case, coercion may be more subtle, and hence more difficult to identify, when exercised on individuals who are not fully self-determinant, and may therefore lack the cognitive and emotional skills and the socio-economic and political means to express dissent. This implies that we may need to exercise more careful scrutiny to unveil hidden forms of childhood coercion.

However, assumptions about children's lack of competence have been challenged in the academic literature for some time, particularly since the publication of the United Nations Convention on the Rights of the Child in 1989, whose Article 12 states children's right to express their views in all matters concerning their life (United Nations, 1989). Minors do not constitute a homogenous group; on the contrary, childhood has a 'developmental nature' which means that while growing up children show evolving capacities (Nuffield Council on Bioethics, 2015). This means that it is hard to identify a cut-off point when autonomous decision-making can and ought to be attributed, and there is increasing recognition that some minors, especially the so-called 'mature minors', are capable of forming their own views, for instance regarding treatment choices (Dickens & Cook, 2005; Manzini & Vears, 2018). Therefore, it is important to question generalising views of all children as vulnerable, particularly since labels of vulnerability can be used to justify interventions that risk crossing the subtle distinction between care and control, thus legitimising paternalistic interventions that may have a disciplinary function (Brown, 2014).

There is insufficient space to explore these issues in more detail here, however, the above considerations should serve as a reminder of the importance of keeping in mind both young people's potential vulnerabilities and also their potential for capacity and autonomy, when considering the possibility of coercion in early intervention.

4 What counts as 'public health benefit' is itself contestable because of conflicting views about the boundaries of public health and which approach to justice we should employ in optimising it (Coggon, 2012; Verweij & Dawson, 2007). Space constraints forbid a fuller exposition of this here.

5.1. Is coercion always wrong?

Although its connotations are typically negative, it is arguable that coercion is not necessarily unethical in all cases. Insofar as coercion consists in the limiting of individual freedoms, there are instances in which coercion is *prima facie* permissible. Examples include: deprivation of individual liberty through quarantine to stop the spread of infectious diseases; or hypothetical future disaster scenarios, for instance uncontrollable climate change and resource depletion, that might justify efforts to protect the good of the population by curtailing personal liberty. Although these are relatively straightforward examples of justified coercion, it is fair to note that even they are more complicated than they appear, as well defended opposing analyses exist regarding coercion's normative status that we do not have space to attempt to settle here. For example, Ryan (1980) holds that since the wrongness of coercion is grounded in whether one has a right to resist whatever proposal is being made, and since rights are irreducibly normative insofar as they are necessarily comprised of talk of duties and obligations, so a non-normative account of coercion must be similarly inconsistent. By contrast, summarising the opposite position that coercion is not irreducibly normative, Anderson (2017) notes that *'if coercion is necessarily immoral action, then it is hard to explain how an act of coercion could count as justified'*. In short, Anderson's claim is that if coercion were *necessarily* immoral it could not be successfully defended.

Moreover, not only is the debate regarding the normative status of coercion persistent, but even relatively unproblematic instances of justified coercion may have stringent conditions of permissibility. For example, as Giublini et al. (2018) demonstrate, just because an instance of coercion such as quarantine may be justifiable, this justifiability turns significantly on the state meeting its reciprocal duties to ensure that people held in quarantine are kept in conditions under which their basic needs are met and in which the burden of quarantine is made as easy as possible to bear. This may sound like a stipulation that can be easily satisfied; however, given that instances of quarantine are often correlated with areas in the developing world where health and welfare resources are especially limited, it may in fact be extremely difficult for states to meet the reciprocal obligations which would ensure that the forced curtailment of liberty is satisfactorily compensated for.

In short, there are considerable theoretical and practical challenges inherent to determining the conditions under which coercion may or may not be justified. Nevertheless, and notwithstanding how formidable these challenges might be, if we conclude that there *are* circumstances in which the involuntarily curtailment of freedom is permissible, such instances suggest that the moral status of coercion is not uniform and thus cannot be assumed to be *a priori* morally objectionable without analysis of the details of a particular case.

With the preceding analysis in mind, an instructive example closely connected to the subject of this paper, namely the welfare of minors, is mandatory education. Parents are compelled by the state under pain of prosecution to have their children educated even if they do not wish to (Bostrom & Sandberg, 2009). The benefits for individual children and society are so great, however, that if a parent did not wish to have their children educated the state would be justified in coercing the parent to do so. To underline the point, although our nominal, pre-theoretical, assumptions about coercion are typically negative, the label may not in fact be sufficient for determining whether an intervention is or is not permissible. We therefore need to disentangle the reasons for this when applying it to our context. Wertheimer (1993, p. 239) distinguishes between two philosophical questions relating to coercion:

> *. (a) what constitutes or counts as coercion? (b) what justifies the use of coercion? To exemplify, consider two questions about the use of kidneys for transplants. Whether poor people who sell their kidneys are coerced by their circumstances to do so (as many have argued) is a type (a) problem. By contrast, whether (as fewer have argued) the state is justified in coercively removing kidneys from healthy persons in order to save others is a type (b) problem*

In our context, whether children and adolescents are coerced to receive state-mandated support, treatment, or punishment (depending on how one defines the interventions proposed) in view of their behaviour is a type (a) question; and whether it is justifiable for the state to do so is a type (b) question. In answering type (a) questions, determining whether someone *is in fact* coerced may be answered by considering whether empirical, psychological, or moral considerations suggest that the person has been made worse off through violation of their baseline rights. Answering type (b) questions similarly requires an appeal to particular circumstances in judging whether or not the state's *reasons* for proposing the coercive act are acceptable.

On what Wertheimer (1993, p. 239) describes as an *'analytic'* (type a) view, minors (or their parents or guardians) would be coerced to receive interventions if the threat of not complying with them is such that it would leave them with no rational choice (for example in the sense that if someone has a gun to my head I only have a limited choice about whether or not to comply with their demands). On an alternative, (type b) *'moralised'* (Wertheimer, 1993, p. 239) view, however, minors would only be coerced to receive a given intervention if the state is wrong to propose it. On this view, if the state is right to make the proposal, the minors (or their parents or guardians) in question are not coerced *even if* they are left with little realistic choice but to comply.

5.2. What counts as coercion?

Let us consider the type (a) question first, that is, the analytic question of one's realistic freedom to choose between options in the face of a proposal by another. Coercion may take various different forms and have more or less oppressive consequences depending upon the circumstances in which the proposal is made. For example, a minor who displays behaviour deemed concerning is less likely to be at risk of coercive intervention from the state if he is growing up within affluent social circumstances (Viner et al., 2012; Wacquant, 2010). However, although such a young person is less at risk of coercion from the state, he may be at risk of coercion from his parents or peers, who could place pressure on him to access stimulant medication in order to enhance his academic performance, particularly during exam periods (DeSantis, Webb, & Noar, 2008; Hall, Irwin, Bowman, Frankenberger, & Jewitt, 2005). By contrast, a minor is likely to be at greater risk of coming to the attention of state authorities if their circumstances are adverse and they have less socioeconomic capital (Bottrell, 2009; Kemshall, 2008), even if they have not yet displayed what are taken to be symptoms of a disorder. Thus, while both children are at risk of coercion, the consequences of coercion may be more oppressive and severe for the second child, since he lacks the social capital that could give him access to more resources and options (NICE, 2014; Parkin, Long, & Bate, 2018), and because he is more likely to come to the attention of state authorities.

Conceptions of autonomy as relational are relevant here. According to such accounts the nature and extent of autonomy are dependent on the socially-determined choices that are available to an individual. On the relational view, all people are interdependent and exist in webs of relationships, and the individual need not be abstracted from this context before she can be said to be autonomous (Christman, 2014; Mackenzie, 2002, 2008). Relational autonomy thus contrasts with the traditional liberal account in which autonomy is understood in purely theoretical terms as an individual's right to choose abstracted from the contingencies in which a choice must be made. What the two theoretical examples remind us is that one's choices will be constrained or extended by the particular circumstances in which one finds oneself. As such, and unjustly, some will be more fortunate in their range of options than others. We are not saying here, therefore, that it is wrong for the state to intervene in cases where a minor needs support that they do not have. However, this highlights the structural differences which place some children at a disadvantage and at greater risk of state coercion for behaving no worse than other, more fortunate, children whose behaviour poses less of a risk to their liberty in view of their social advantage.

Having said this, one might still think that there are reasons to favour interventions of the kind we are considering. It is, after all, reasonable to want minors to grow up in ways that enable them to flourish and are not held back by their circumstances and it is similarly reasonable to desire a populous comprised of mutually supportive and socially-minded individuals. However, concerns arise when those who advocate a particular

intervention *assume* the values, needs, and goals of the minor who is the intended recipient of the intervention. This can be demonstrated via the following quote from the UK Government 'Future in Mind' report:

> *All the professionals you meet should treat you as a whole person, considering your physical and mental health needs together. You are experts in your care and want to be involved in how mental health services are delivered and developed, not just to you and those who support you, but to all the children, young people and families in your area. If things aren't going well, the team providing your care will work with you to make changes to achieve your goals. You have the opportunity to shape the services you receive. That means listening to your experience of your care, how this fits with your life and how you would like services to work with you. It means giving you and those who care for you the opportunity to feedback and make suggestions about the way services are provided*
>
> (Department of Health, 2015, p. 11).

Here the report adopts a language of agency and choice which implies that young people *really do* have the freedom to choose between options and *'shape the services [they] receive'*. However, the report assumes that the minors in question have and are aware of having the kinds of needs and goals that would lead them to want assistance and moreover some well-formed wider view of what is also best for other young people. There is no problem with this to the extent that the minors to whom support is proposed confirm that they have the same kinds of needs and goals envisaged by the architects of the report. However, it is important to consider what would be the case if the minors involved profess to have goals and needs that deviate from that vision and wish to shape their choices towards different ends. Given the breadth of the criteria for what might be considered as having ADHD or CD, and given that many of the forms of behaviour covered by the diagnostic criteria may, if taken individually, be ultimately benign even if temporarily inconvenient to parents, teachers or other adults in positions of responsibility, the language used in the policy risks shrinking the potential space for young people to exercise their freedom and dissent from intervention.

5.3. Justified coercion?

Having considered whether a specific instance *constitutes* coercion, we will explore the type (b) question by considering whether coercion is ever *justifiable* in the context of early intervention for mental health. One reason to think that coercion is not justifiable is if we were to judge the risk of harm to the individual so great that it is not outweighed by potential benefits to society. This might occur if early intervention or prevention cause stigma by medicalising normal behaviour or exerting excessive control over an individual's autonomous choices such that the infringement of their liberty causes them harm. Indeed, criticism of the type (b) view turns on the claim that in allowing circumstances in which the normative force of coercion is neutralised, the moralised view is (Arnold, 2001, p. 54):

> *.unable to account for the prima facie wrongness of coercion. Coercion is prima facie harmful because it undermines individual freedom. coercion is a 'vice word,' one that carries with it a negative normative judgement. This judgment is based on a strong moral presumption against the forced restriction of individual freedom*

As Arnold notes, it conflicts with our intuitions about coercion to consider that there are instances in which it is permissible: coercion does indeed often strike us as *prima facie* wrong. However, that it conflicts with our intuitions does not *prove* that it is wrong. One might respond to Arnold's claim by noting that it implies we should assume that our duties to society are necessarily subordinate to duties to individuals, but this would also be *prima facie* wrong. It is not obvious why we should assume that our duties to one outweigh our duties to the other without reference to the context in which a decision is to be made.

Nevertheless, given the centrality of autonomy to moral thought in general and contemporary moral thought in particular, and with respect to the risk that Arnold underlines, the view that coercion is a *'vice word'* has force. Consistent with concerns about the legitimacy of curtailing individual freedoms in the name of social order, Szasz (1958; 1976) and others have highlighted reasons to be wary of the fundamental validity of applying diagnostic labels to behaviour:

> *.his diagnosis, becomes a 'personal fact' in the child's life which follows him into every nook and cranny of our society and surfaces in countless questionnaires which ask: 'Have you ever seen a psychiatrist?' or 'Have you ever been treated for mental illness?..' (1976, p. 1012)*

Moreover, psychiatric labels can in themselves be coercive, insofar as they can be used to reinforce social norms. The history of psychiatry includes several examples of past injustices in cases such as homosexuality, masturbation, female hysteria, drapetomania, all of which have been labelled as psychiatric illnesses and used perniciously to incarcerate individuals, or to force them into conversion therapies. As Bentall and Pilgrim (1993, p. 71) point out, historical antecedents in which behaviour has been medicalised suggest that it is *'undoubtedly correct to point to the social control function of psychiatry'*.

The history of coercive use of psychiatric labels as well as the restrictive consequences of psychiatric labelling means that what we might call 'justified coercion' is a substantively relevant and important ethical dimension of early intervention in children's problem behaviours. Economic and normative arguments given in favour of intervening to curb certain kinds of behaviour under the label of one of these diagnoses and in the name of public health require scrutiny, as we have said, because of their rhetorical power. Moreover, once we use aggregate benefit as our unit of measurement, as is the case in public health, anything can be justified assuming its beneficiaries are sufficiently numerous.

Of course, we do not want to suggest that *all* behaviour, however unruly or antisocial, is permissible, since this would be counter-productive; nor do we suggest that minors may not benefit from interventions to curtail certain kinds of behaviour for their own good. However, if there are reasons to think that policy is developed with socio-political ends which require scrutiny and reflection, the preceding analysis highlights that *even if* we believe the state may in principle be justified in intervening, there are sufficient grounds to consider it potentially coercive enough in certain cases to require further attention.

Although arguments in favour of curbing certain kinds of behaviour have merit in view of the consequences for individuals and society, policies proposed for this purpose may also risk entrenching the positions of individuals who are already more likely to be in a position of social disadvantage. As we noted, given the looseness of the definitions of ADHD and CD, many children may be labelled with one and/or the other in ways that cause harm. In this respect the validity, reliability and utility of the labels is uncertain, and we should be wary of what they can be exploited to support.

6. Conclusion

We can bring the various strands together here and open our conclusion by drawing briefly on nudge literature. The nudge literature is extensive and constitutes a major body of research in its own right. As such, the analogy we draw here is for the purposes of underlining what is important in our key argument, rather than for placing any particular emphasis on the significance of nudging in the context we are considering.

Nudging exploits cognitive biases to persuade individuals to pursue certain courses of action rather than others, towards an outcome deemed preferable to the alternatives. They are frequently used in public health (as well as in marketing and behavioural economics) as a way to promote healthy lifestyle choices. For example, in shops fruit or healthy snacks rather than sweets may be placed closer to checkouts, on the basis that by the time they

reach the checkout people are more likely to choose what is nearby and convenient to reach rather than to resume shopping and seek out less healthy options.

Although nudges may promote healthy choices in ways which yield public health benefits, it has been argued in the literature that the risk is that they do this by infantilising individuals or denying them the opportunity to arrive at fully informed choices by making mistakes and reflecting thereon (Baldwin, 2014; Schmidt, Voigt, & Wikler, 2010; Selinger & Whyte, 2011, 2012; Yeung, 2012).

It is of course fair to note that others have disputed whether nudges infringe autonomy in any meaningful or damaging way. Quigley (2014), for example, holds that nudges such as displaying food options in such a way that healthy ones are easier to select than less healthy cannot count as coercive because, irrespective of any pressure to make the healthier choice, *'The choice of food in the queue is not an "or else" proposition. The new food policy does not say "choose the healthy option or else you do not eat at all"'*. This observation is correct; however, it does not undermine the point that we are making. Of course it is still *possible* to make the unhealthy choice, but this has no bearing on those who *do* make the healthy choice because it is easier. We do not claim that minors should be permitted to do whatever they wish, however personally or interpersonally damaging, because of a belief that this is the only way that they will learn; this would be a caricature of the position. Rather, we contend that the question as to whether a decision can be properly informed and autonomy properly protected if the choice architecture is designed in such a way that certain choices, deemed unacceptable by the architects rather than the consumers, are less likely to be made, and subsequently reflected upon, for reasons of convenience alone.

We do not need to pursue this any further here and space forbids a fuller analysis of the nudge literature. Nevertheless, it is this general line of argument concerning the risks of infantilisation which illustrates what is important in the context that we have been considering in this chapter, since if one is not permitted the latitude to engage in behaviour which it turns out one would not repeat or will perhaps regret, how is one to *know*, in a sense that goes beyond the theoretical, that one should not do it? Indeed, according to some theories of moral development, it is practice and training of moral thinking and action that drive the realisation of the good person, who, by definition, enacts good behaviours (MacIntyre, 1985).

We suggest that the duty to protect the mental wellbeing of young people must therefore also incorporate the duty to ensure that they are able to develop authentic and fully realised agency as adults. In some cases, engaging in certain kinds of behaviour *is* indeed likely to result in adverse outcomes and impede their ability to realise their plans, and this is a risk to be taken seriously. Equally, however, if one goal of public health is to have a citizenry that is, for example, *both* responsible for themselves *and* tolerant of others - who, indeed, may have values and views with which one disagrees or of which one disapproves - then it is also important not to narrow unduly the range of options for minors to acquire these aspects of character while agency and moral capacity are developing.

With this in mind, in some cases the framing of mental health support for minors may risk shrinking their developmental options in ways that are counter-productive. Although certain kinds of behaviour *are* undesirable or inconvenient, it does not follow from this that we should seek their prevention in all cases. For the reasons outlined here, therefore, we contend that the vagueness of the criteria for ADHD and mild CD may be exploited in ways that are malignly, rather than beneficently, coercive. We therefore argue that taking seriously the legitimacy of right to refuse intervention should be protected.

Finally, although the early intervention approach which drives these policies claims to be against the medicalisation of mental health – because social solutions are applied before they become serious enough to warrant clinical intervention – the risks raised by Szasz and others are not neutralised. It is irrelevant whether the proposed care solutions are medical or social in nature (Horstk€otter & Berghmans, 2014). With regard to surveillance, once a young person comes to the attention of the state displaying behaviour that it regards as a problem which carries a medical diagnosis, there is a utility-driven justification for mandating interventions

denoted as support (Foresight Mental Capital and Wellbeing Project, 2008). We suggest that this justification may cause harm in ways that are hidden by the elegance of the solution in which individual and societal goals are apparently demonstrated as necessarily mutually consistent and harmonious. Rather, dissent should not automatically be assumed to be illegitimate, unreasonable, antithetical to the realisation of outcomes that are all-things-considered desirable, nor necessarily contrary to public mental health.

Given the utility-driven justificatory basis of arguments in public health, for the reasons outlined earlier they clearly offer scope for coercion, since anything is in principle justifiable if it maximises overall good in a statistical sense. Now, as we have argued, coercion is permissible in some circumstances even if we commit to the view that it is *prima facie* wrong. Many things are *prima facie* wrong but permissible depending on the circumstances – deliberate killing in self-defence, for example - and so it is with efforts needed to safeguard people from harm and ensure that they can develop in ways that are good for them and the social context in which they live. If it is the case that compelling people to make certain kinds of decisions does yield these outcomes then the answer to the initial question is that coercion can indeed sometimes be beneficent. However, caution is needed.

The notion of the ideal citizen who always acts in their own interests and those of society, as often advanced by policymakers, is seductive, but precisely because it is an ideal it is important to remember that it cannot be realised. It is of course fair to note here that interventions such as nudges are designed in the way that they are precisely *because* humans are imperfect reasoners and because, therefore, their cognitive biases can be exploited to direct behaviour in certain ways. However, our analysis of the relevant policy material suggests that what is recognised here by behavioural scientists and economists is easily lost in the move from theory to practice. The necessarily political ends of policy making do not always lend themselves to nuance, and consequently it is expedient to present an oversimplified picture in wich it appears obvious that the 'good' citizen is necessarily a person who acts in certain tightly sanctioned ways and, by implication, does not engage in behaviour contrary to it.

We contend that the idealised representations which contribute to the apparent unarguability of certain policy edicts may be counter-productive. All people are fallible and in the interests of protecting each other's wellbeing it is important that some latitude is given mutually, especially in the case of young people who are developing into adults, rather than automatically considering deviations from the ideal citizen's behaviour as either malign in nature or indicative of the presence of a serious mental health condition requiring correction. In these cases, the circumstantial facts about to whom a proposal to intervene is made and why, and what the likely effects of intervening are likely to be in view of those circumstances, can substantially influence the ethical landscape of individual cases in ways which demand close scrutiny to determine whether any coercion into treatment is or is not permissible.

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References

American Psychiatric Association. (2013). *Conduct disorder*. Retrieved August 15, 2018, from Available at: https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets.

Anderson, Scott, & Coercion. (2017 Edition). The Stanford Encyclopedia of Philosophy. In Edward N. Zalta (Ed.), *Winter*. Available at: https://plato.stanford.edu/archives/win2017/entries/coercion/.

Arnold, D. G. (2001). Coercion and moral responsibility. *American Philosophical Quarterly*, *38*(1), 53–67.

Baldwin, R. (2014). From regulation to behaviour change: Giving nudge the third degree. *The Modern Law Review*, *77*(6), 831–857.

Beauchaine, T. P., Hinshaw, S. P., & Pang, K. L. (2010). Comorbidity of attention-deficit/hyperactivity disorder and early-onset conduct disorder: Biological, environmental, and developmental mechanisms. *Clinical Psychology: Science and Practice*, *17*(4), 327–336.

Bentall, R. P., & Pilgrim, D. (1993). Thomas Szasz, crazy talk and the myth of mental illness. *Journal of Medical Psychology*, *66*(1), 69–76.

Biederman, J., Petty, C. R., Dolan, C., Hughes, S., Mick, E., Monuteaux, M. C., & Faraone, S. V. (2008). The long-term longitudinal course of oppositional defiant disorder and conduct disorder in ADHD boys: Findings from a controlled 10-year prospective longitudinal follow-up study. *Psychological Medicine*, *38*(7), 1027–1036. PubMed PMID: 18205967.

Bostrom, N., & Sandberg, A. (2009). Cognitive enhancement: Methods, ethics, regulatory challenges. *Science and Engineering Ethics*, *15*(3), 311–341. PubMed PMID: 19543814.

Bottrell, D. (2009). Dealing with disadvantage: Resilience and the social capital of young people's networks. *Youth and Society*, *40*(4), 476–501.

Brown, K. (2014). Questioning the vulnerability zeitgeist: Care and control practices with 'vulnerable' young people. *Social Policy and Society*, *13*(3), 371–387.

Christman, J. (2014). Relational autonomy and the social dynamics of paternalism. *Ethical Theory and Moral Practice*, *17*(3), 369–382.

Coggon, J. (2012). *What makes health public?A critical evaluation of moral, legal and political claims in public health*. Cambridge: Cambridge University Press.

Cortese, S., Adamo, N., Del Giovane, C., Mohr-Jensen, C., Hayes, A. J., Carucci, S., … Hollis, C. (2018). Comparative efficacy and tolerability of medications for attentiondeficit hyperactivity disorder in children, adolescents, and adults: A systematic review and network meta-analysis. *The Lancet Psychiatry*, *5*(9), 727–738. PubMed PMID: 30097390.

Davies, C., & Bromley-Derry, K. (2010). *Grasping the nettle: Early intervention for children, families and communities*. Centre for Excellence and Outcomes in Children and Young People's Services. Retrieved from Available at: https://www.bl.uk/collection-items/grasping-thenettle-early-intervention-for-children-families-and-communities.

Department of Health. (2015). *Future in mind - promoting, protecting and improving children and young people's mental health and wellbeing*. London. Retrieved from Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf.

Department of Health. (2017). *A framework for mental health research*. London. Retrieved from Available at: https://www.gov.uk/government/publications/a-framework-for-mental-health-research.

DeSantis, A. D., Webb, E. M., & Noar, S. M. (2008). Illicit use of prescription ADHD medications on a college campus: A multi-methodological approach. *Journal of American College Health*, *57*(3), 315–324. PubMed PMID: 18980888.

Dickens, B. M., & Cook, R. J. (2005). Adolescents and consent to treatment. *International Journal of Gynaecology & Obstetrics*, *89*(2), 179–184. PubMed PMID: 15847892.

DuPaul, G. J., & Stoner, G. (2014). *ADHD in the schools: Assessment and intervention strategies* (3rd ed.). New York: Guilford Press.

Foresight Mental Capital and Wellbeing Project. (2008). *Final Project report*. London: The Government Office for Science.

Gérardin, P., Cohen, D., Mazet, P., & Flament, M. F. (2002). Drug treatment of conduct disorder in young people. *European Neuropsychopharmacology*, *12*(5), 361–370. PubMed PMID: 12208553.

Greely, H., Sahakian, B., Harris, J., Kessler, R. C., Gazzaniga, M., Campbell, P., & Farah, M. J. (2008). Towards responsible use of cognitive-enhancing drugs by the healthy. *Nature*, *456*(7223), 702. PubMed PMID: 19060880.

Hall, K. M., Irwin, M. M., Bowman, K. A., Frankenberger, W., & Jewitt, D. C. (2005). Illicit use of prescribed stimulant medication among college students. *Journal of American College Health*, *53*(4), 167–174. PubMed PMID: 15663065.

Horstk€otter, D., & Berghmans, R. (2014). Early prevention of antisocial behavior (ASB): A comparative ethical analysis of psychosocial and biomedical approaches. *BioSocieties*, *9*(1).

Hyman, S. E. (2010). The diagnosis of mental disorders: The problem of reification. *Annual Review of Clinical Psychology*, *6*, 155–179.

Jones, K., Daley, D., Hutchings, J., Bywater, T., & Eames, C. (2008). Efficacy of the incredible years programme as an early intervention for children with conduct problems and ADHD: Long-term follow-up. *Child: Care, Health and Development*, *34*(3), 380–390.

Kemshall, H. (2008). Risks, rights and justice: Understanding and responding to youth risk. *Youth Justice*, *8*(1), 21–37.

Khan, L., Parsonage, M., & Stubbs, J. (2015). *Investing in children's mental health report*. London. Retrieved from Available at: https://www.centreformentalhealth.org.uk/investing-in-children-report.

Khong, B. (2014). *The lifetime costs of attention deficit hyperactivity disorder (ADHD)*. London: Centre for Mental Health. Retrieved September 6, 2018, from Available at: https://www.centreformentalhealth.org.uk/publications/lifetime-costs-of-adhd.

MacIntyre, A. (1985). *After virtue: A study in moral theory*. London: Duckworth.

Mackenzie, C. (2002). Critical reflection, self-knowledge, and the emotions. *Philosophical Explorations*, *5*(3), 186–206.

Mackenzie, C. (2008). Relational Autonomy, normative authority, and perfectionism. *Journal of Social Philosophy*, *39*(4), 512–533.

Manzini, A., & Vears, D. F. (2018). Predictive psychiatric genetic testing in minors: An exploration of the non-medical benefits. *Journal of Bioethical Inquiry*, *15*(1), 111–120. PubMed PMID: 29230699.

McGorry, P., & Pelosi, A. (2008). Is early intervention in the major psychiatric disorders justified? *British Medical Journal*, *338*, a695.

Mental Health Task Force. (2016). *The five year forward view for mental health*. London. Retrieved September 16, 2018, from Available at: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

Merten, E. C., Cwik, J. C., Margraf, J., & Schneider, S. (2017). Overdiagnosis of mental disorders in children and adolescents (in developed countries). *Child and Adolescent Psychiatry and Mental Health*, *11*, 5. PubMed PMID: 28105068.

Moldavsky, M., & Sayal, K. (2013). Knowledge and attitudes about attention-deficit/hyperactivity disorder (ADHD) and its treatment: The views of children, adolescents, parents, teachers and healthcare professionals. *Current Psychiatry Reports*, *15*, 337–377. PubMed PMID: 23307560.

Mortimer, R., McKeown, A., & Singh, I. (2018). Just policy? An ethical analysis of early intervention policy guidance. *The American Journal of Bioethics*, *18*(11), 43–53.

NHS. (2013). *New guidelines on child antisocial behaviour*. Retrieved August 15, 2018, from Available at: https://www.nhs.uk/news/pregnancy-and-child/new-guidelines-on-child-antisocialbehaviour/#how-common-are-conduct-disorders.

NHS. (2018). *Attention-deficit hyperactivity disorder (ADHD)*. Retrieved September 6, 2018, from Available at: https://www.nhs.uk/conditions/attention-deficit-hyperactivity-disorder-adhd/.

NICE. (2014). *NICE support for commissioning for antisocial behaviour and conduct disorders in children and young people*. London.

Nuffield Council on Bioethics. (2015). *Children and clinical research*. London, United Kingdom.

Olds, D. (2007). Preventing crime with prenatal and infancy support of parents: The nursefamily partnership. *Victims & Offenders*, *2*(2), 205–225.

Parens, E., & Johnston, J. (2009). Facts, values, and attention-deficit hyperactivity disorder (ADHD): An update on the controversies. *Child and Adolescent Psychiatry and Mental Health*, *3*(1).

Parkin, E., Long, R., & Bate, A. (2018). *Children and young people's mental health: CAMHS policy, services and education*. London. Retrieved from Available at: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7196.

Potter, N. (2016). *The virtue of defiance and psychiatric engagement*. Oxford: Oxford University Press.

Quigley, M. (2014). Are health nudges coercive? *Monash Bioethics Review*, *32*(1–2), 141–158. PubMed PMID: 25434069.

Rafalovich, A. (2004). *Framing ADHD children: A critical examination of the history, discourse, and everyday experience of attention deficit/hyperactivity disorder*. Lanham: Lexington Books.

Ragan, I., Bard, I., & Singh, I. (2013). What should we do about student use of cognitive enhancers? An analysis of current evidence. *Neuropharmacology*, *64*, 588–595. PubMed PMID: 22732441.

Ryan, C. C. (1980). The normative concept of coercion. *Mind*, *89*(356), 481–498.

Schmidt, H., Voigt, K., & Wikler, D. (2010). Carrots, sticks, and health care reformdproblems with wellness incentives. *New England Journal of Medicine*, *362*(2), e3. PubMed PMID: 20042747.

Scott, S. (2008). An update on interventions for conduct disorder. *Advances in Psychiatric Treatment*, *14*(1), 61–70.

Scott, S., Knapp, M., Henderson, J., & Maughan, B. (2001). Financial cost of social exclusion: Follow up study of antisocial children into adulthood. *British Medical Journal*, *323*(7306), 191. PubMed PMID: 11473907.

Selinger, E., & Whyte, K. (2011). Is there a right way to nudge? The practice and ethics of choice architecture. *Sociology Compass*, *5*(10), 923–935.

Selinger, E., & Whyte, K. (2012). Nudging cannot solve complex policy problems. *European Journal of Risk Regulation*, *3*(1), 26–31.

Singh, I. (2018). *ADHD in the United Kingdom: Conduct, class, and stigma*. Global perspectives on ADHD: Social dimensions of diagnosis and treatment in sixteen countries: M. R. Bergey, A. M. Filipe, P. Conrad and I. Singh. Johns Hopkins University Press.

Singh, I. (2016). Evidence, epistemology and empirical Bioethics. In J. Ives, M. Dunn, & A. Cribb (Eds.), *Empirical bioethics: Theoretical and practical perspectives* (Vol. 37, pp. 67–83). Cambridge: Cambridge University Press.

Singh, I., Filipe, A. M., Bard, I., Bergey, M., & Baker, L. (2013). Globalization and cognitive enhancement: Emerging social and ethical challenges for ADHD clinicians. *Current Psychiatry Reports*, *15*(9), 385. PubMed PMID: 23933975.

Singh, I., & Rose, N. (2009). Biomarkers in psychiatry. *Nature*, *460*, 202–207. PubMed PMID: 19587761.

Singh, I., & Wessely, S. (2015). Childhood: A suitable case for treatment? *The Lancet Psychiatry*, *2*(7), 661–666. PubMed PMID: 26303563.

Skogli, E. W., Teicher, M. H., Andersen, P. N., Hovik, K. T., & Øie, M. (2013). ADHD in girls and boys - gender differences in co-existing symptoms and executive function measures. *BMC Psychiatry*, *13*(298).

Sonuga-Barke, E. J. S., Daley, D., Thompson, M., Laver-Bradbury, C., & Weeks, A. (2001). Parent-based therapies for preschool attention-deficit/hyperactivity disorder: A randomized, controlled trial with a community sample. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(4), 402–408. PubMed PMID: 11314565.

Szasz, T. S. (1958). Psychiatry, ethics, and the criminal law. *Columbia Law Review*, *58*(2), 183–198.

Szasz, T. S. (1976). Child as involuntary mental patient: The threat of child therapy to the child's dignity, privacy, and self-esteem. *The San Diego Law Review*, *14*, 1005.

The Family Nurse Partnership. (2018). *The Family Nurse Partnership: About us*. Retrieved September 6, 2018, from Available at: http://fnp.nhs.uk/about-us/.

United Nations, General Assembly. (1989). Convention on the rights of the child, 20 November 1989. *Annual Review of Population Law*, *16*(95), 485–501.

Verweij, M., & Dawson, A. (2007). The meaning of "public" in "public health". In A. Dawson, & M. Verweij (Eds.), *Ethics, prevention and public health* (pp. 13–29). Oxford: Oxford University Press.

Villodas, M. T., Pfiffner, L. J., & McBurnett, K. (2012). Prevention of serious conduct problems in youth with attention deficit/hyperactivity disorder. *Expert Review Neurotherapeutics*, *12*(10), 1253–1263.

Viner, R. M., Ozer, E. M., Denny, S., Marmot, M., Resnick, M., Fatusi, A., & Currie, C. (2012). Adolescence and the social determinants of health. *The Lancet*, *379*(9826), 1641–1652.

Wacquant, L. (2010). Crafting the neoliberal state: Workfare, prisonfare, and social insecurity. *Sociological Forum*, *25*(2), 197–220.

Wertheimer, A. (1993). A philosophical examination of coercion for mental health issues. *Behavioral Sciences & the Law*, *11*(3), 239–258.

Yeung, K. (2012). Nudge as fudge. *The Modern Law Review*, *75*(1), 122–148.

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