


**A Critical Curriculum on Psychotropic Medications**




## A Critical Curriculum on Psychotropic Medications

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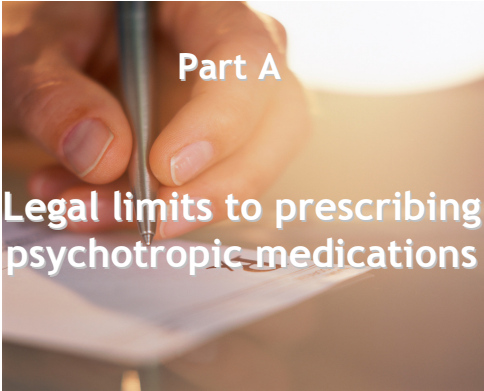


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## Module 6

### Non-Medical Professionals and Psychotropic Medications: Legal, Ethical and Training Issues

**Part A**

## Legal limits to prescribing psychotropic medications

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## Who can prescribe?

Most states grant full or partial prescriptive authority to licensed physicians, dentists, advanced nurse practitioners, pharmacists, podiatrists, and optometrists



(NASW, 2005; Norfleet, 2002; Wiggins & Wedding, 2004)

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### Who cannot prescribe?

Social workers, mental health counselors, and most psychologists are not authorized to **prescribe, dispense, or administer** any medication



(NASW, 2005; Norfleet, 2002; Wiggins & Wedding, 2004)

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### Discussing any and all medication issues with clients is OK

For example, Florida and California do not prohibit non-medical professionals to discuss any medication issue with clients

A review of case law indicates that this could not be construed as practicing medicine without a license

(Cohen, 2007; Ingersoll, Bauer, & Burns, 2004; Littrell, 2003; Littrell & Ashford,<sup>8</sup>1995)

### Psychologists have gained limited authority to prescribe in 2 states and 1 U.S. territory

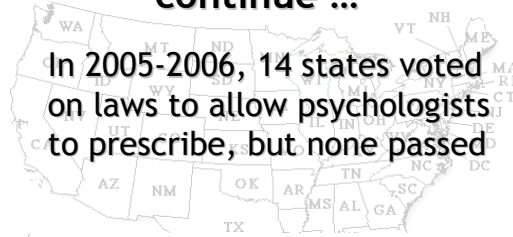
New Mexico (2002)      Specially-trained  
Louisiana (2004)      Department of  
Guam (1998)            Defense  
   psychologists  
   also may  
   prescribe



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### Psychologists' efforts continue ...

In 2005-2006, 14 states voted on laws to allow psychologists to prescribe, but none passed



March 26, 2002

Psychologists Get Prescription Pads And Furor Erupts

The New York Times

(Goode, 2002; Long, 2005; McGrath et al., 2004; Norfleet, 2002)

### Issue is debated...

- Who needs psychologists to prescribe?
- What special training is needed?
- Is it simply about more money?
- Is psychology selling its soul for a mess of (pharmaceutical) pottage?

but the discussion has shifted from "Should psychologists prescribe?" to "When will they prescribe and how should they prepare?"

(Heiby, 2002; Kenkel, 2006; Sanua, 2003)

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### Are counselors next?

Among members of the American Mental Health Counselors Association,

- 41% would like to pursue independent prescription privileges
- 64% would like to obtain dependent privileges
- > 90% want psychopharmacology training in their curriculum



(Scovel, Christensen, & England, 2002)

## How about social workers?

Survey of a national sample of 176 practitioners in late 1990s

- 52% opposed to obtaining prescription privileges
- 19% in favor
- the rest said “maybe” or did not respond

(Piotrowski & Doelker, 2001)



## Professional associations' stances

American Psychological Association supports psychologists' efforts to gain prescriptive authority

National Association of Social Workers views prescription as beyond the scope of the profession

American Psychiatric Association actively opposes all such initiatives from non MDs



## Part B

**Ethical and Legal Issues:  
Competence and Training  
Informed Consent  
Confidentiality**



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**Professional *competence* is a core principle in the codes of ethics and standards for practice of various helping professions**

(ACA, AMHCA, APA, NASW)

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**To maintain competence, professional codes recommend**

Education and training  
Consultation  
Supervision  
Continuing education

(ACA, AMHCA, APA, NASW)

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## Competence requires

- ✓ knowledge of valid information relevant to practice
- ✓ regular critical review of literature and emerging information
- ✓ participation in relevant and unbiased CE

(ACA, AMHCA, APA, NASW)

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No specific standards address working with clients and others around medication-related issues

In the absence of standards, Codes advise exercising careful judgment and taking responsible steps to ensure competence and protect clients from harm

(ACA, AMHCA, APA, NASW)

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## Knowledge = Competence Training = Knowledge

Without knowledge about drugs, counselors, psychologists and social workers are ill-prepared to meet their clients' needs

*Psychopharmacology should be part of training for non-medical practitioners*

(Barnett & Neel, 2000; Bauer, Ingersoll & Burns, 2004; Bentley, 2005; Carlson, Thaler & Hirsch, 2005; Dziegielewski & Leon, 1998; Farmer, Walsh & Dziegielewski, 1998; Ingersoll, 2000)

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**Knowledge increases confidence and empowers non-medical professionals to participate fully in multidisciplinary environments**

(Farmer, Walsh & Bentley, 2006; Dziegielewski, 1998; Littrell, 2003)

## Education vs. indoctrination

Students & practitioners must be *educated* rather than *indoctrinated*, and should be exposed to controversies, uncertainties in knowledge, and well-argued alternatives to popular views

(Dziegielewski, 1998; Gomory & Lacasse, 2001; Litrell, 2003)

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## Special guidelines needed

Use of polypharmacy  
Integrating psychosocial and biological therapies  
Specific groups, such as children, older persons, pregnant women  
Ethical and critical thinking skills in the age of "Big Pharma"

(Buelow & Chafetz, 1996; Chafetz & Buelow, 1994; Dunivin & Southwell, 2000; Freimuth, 1996; Levant & Shapiro, 2002; Smyer et al., 1993)

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**Informed Consent**  
More than just signing a form

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## Why obtain informed consent?

Informed consent is the bedrock of professional practice in a free society

- It promotes the **right to self determination**, prevents harm and provides for the **client's best interest**

(Cohen & Jacobs, 2000; Strom-Gottfried, 1998; Littrell & Ashford, 1995; Littrell & Ashford, 2003)

## What is informed consent?

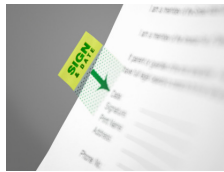
A systematic *process* intended to guarantee the client's right to choose, to privacy and to safety



(Dell et al 2008; Littrell & Ashford, 1995; Littrell, 2003; Strom-Gottfried, 1998)

## What is *not* informed consent?

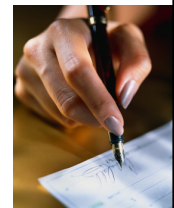
Having a client sign-off on services without a clear understanding of the information, including uncertainties about the treatment



(Cohen & Jacobs, 2000; Littrell & Ashford, 1995; Reamer, 2003) 27

## Validity of consent forms

Blanket consent forms lack specificity and have been challenged in court  
Signing a blank consent form to be completed later *is not* valid consent



(Littrell & Ashford, 1995; Reamer, 2003; Strom-Gottfried, 1998) 28

## Standards for valid consent

1. Avoid coercion and undue influence
2. Assess client competence to consent
3. Specify procedures or actions in the form
4. Inform clients of the right to refuse or withdraw consent
5. Provide adequate information on risks, benefits **and** alternatives to treatment

(Reamer, 2003)

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## Coercion or undue influence

Practitioners who *want* clients to agree to treatments or procedures may be exercising undue influence and will jeopardize validity of their consent

(Dell et al 2008; Littrell & Ashford, 1995; Reamer, 2003; Strom-Gottfried, 1998)

### “Adequate” information

- ✓Critical findings on usefulness, ineffectiveness and reported information on harm
- ✓Description of the hoped-for benefits and how success will be evaluated
- ✓Alternatives to treatment being proposed
- ✓Costs of treatment

(Littrell, 2003; Littrell & Ashford, 1995; Strom-Gottfried, 1998) 31

### Knowledge of alternatives

Lack of knowledge about the alternatives to proposed treatment invalidates informed consent

*Competence by providers in a variety of treatment methods is essential to informed consent*

(Littrell, 2003; Littrell & Ashford, 1995; Strom-Gottfried, 1998) 32

### Encourage questions

Informed consent should serve to empower clients to make intelligent decisions about their care, not protect practitioners from liability

*Practitioners must ensure the persons receiving the information understand it, and should encourage questions*

(Littrell, 2003; Cohen & Jacobs, 2000; Strom-Gottfried, 1998; Tan et al., 2007)

### Competence to consent

“The capacity to act on one’s own behalf, to understand and weigh potential outcomes, to anticipate future consequences of a decision.”

(Tan et al., 2007)

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### Assessing competence to consent

In youths, assessment considers intelligence and cognitive functioning, maturity, impact of any distress, seriousness and urgency of situation, and impact of youth’s relationships

***Refusing to consent does not mean incompetence***

(Dell et al 2008; Tan et al 2007)

### Cognitive capacity of children

By about age 9, children reach the same conclusions as adults, but by different strategies

By about age 14, minors show the same risk-benefit reasoning as adults and can participate in the consent process



(Dell et al 2008; Spetie & Arnold, 2007)

## Respect for autonomy

Older children and adolescents should participate in the consent process in order to protect them from being subjected to treatment procedures against their will, and to respect their developing autonomy and personhood



(Dell et al 2008; Spetie & Arnold, 2007)

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## Third-party representation



Those who cannot give consent require a third party to act “in their best interests”

There are many views on just what this means...

(Spetie & Arnold, 2007)

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## What about preschoolers?

Are parents fully able to carry out their advocacy role?

Their capacity to act in their young child’s best interest warrants careful evaluation



(Dell et al 2008; Spetie & Arnold, 2007)

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*“The clinician must be watchful for caregivers who may have ulterior motives and want a child to be medicated for their own convenience, or because pharmacotherapy may simply be ‘easier’ than behavioral therapy, or as is more often the case, caregivers who have unrealistic expectations about what benefits a treatment may potentially hold for the child.”*

(Dell et al., 2008, p. 105)

## Constitutional right to refuse or withdraw consent

Clients have the right to refuse or withdraw consent at any time and must be informed of this right

State and federal courts have consistently ruled that it is unfair to allow forced medication without “adequate” procedural guidelines

(Bentley, 1993)

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## Forced treatment remains a most controversial issue

Although a fixture of mental health interventions, involuntary treatment must be *literally* “option of last resort”

Opponents of forced treatment assert that it violates one’s fundamental human rights, creates distrust of helpers, and undermines the foundation for recovery

(Bassman, 2005)

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Taking psychotropic medications, having a psychiatric diagnosis, or experiencing major distress, does not by itself provide grounds for being denied the right to refuse or withdraw consent



(Bentley, 1993)

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## Confidentiality



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## Confidentiality vs. privacy

U.S. Constitution guarantees privacy rights, not confidentiality, to the individual

*Confidentiality is essential to develop trust between client and professional*



(Corcoran, Gorin & Moniz, 2005; Hanson & Sheridan, 1997; Millstein, 2000)<sup>45</sup>

## “Duty to protect”

However, the state can breach confidentiality if it has a rationale for seeing the information, such as the “duty to protect” client or others from harm



(Corcoran, Gorin & Moniz, 2005; Millstein, 2000)

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## Relinquishing confidentiality

Managed care organizations and publicly-funded payers require information from providers about clients’

- psychiatric diagnoses
- treatment procedures
- progress and outcomes



(Bilynsky & Vernaglia, 1998; Corcoran, Gorin & Moniz, 2005; Millstein, 2000)

## Ethical mandates

Clients must be informed of, *and authorize*, all disclosures made to insurers and advised of the potential risks of such disclosure *before* disclosure is made

(Reamer, 2001; Millstein, 2000)

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## Part C

### Emerging Legislative Issues

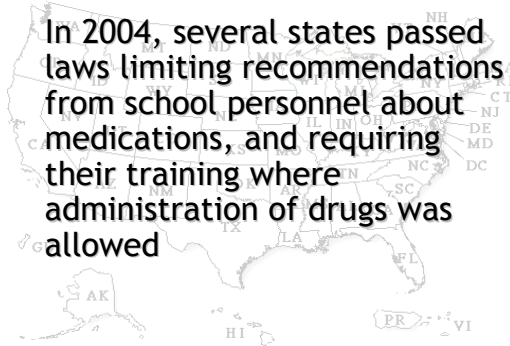
Concerns over medicating children lead to new laws



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### States respond to concerns

In 2004, several states passed laws limiting recommendations from school personnel about medications, and requiring their training where administration of drugs was allowed



**2005:** U.S. House of Representatives passes *Child Medication Safety Act* (H.R. 1790)

- Bill seeks to protect children from being forced to take psychotropic drugs as a pre-condition for attending public school, and intends to restore parental authority over decisions about their children's health

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### Florida limits school's roles F.S. 1006.0625

Public schools cannot require students to receive psychotropic medication as a condition for attending school

*"Any medical decision made to address a student's need is a matter between the student, the student's parent, and a competent health care professional chosen by the parent."*

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### F.S. 39.407 places limits on medicating children in state custody

Children under state care can be medicated only after obtaining *express and informed consent* from the parent, or, if parental rights have been terminated, receiving authorization from a judge

Florida and other states now require state agencies to keep list of foster care children on meds—but no register in U.S. tracks health effects of prescriptions on kids

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### Mental health screening debate

Joining the list of issues hotly debated is a 2003 Presidential task force recommendation to screen all school-aged children for mental health problems



(President's New Freedom Commission Report on Mental Health, 2003)

## Early detection or pharmaceutical ploy?

**Pros:** early detection and treatment of disorders



**Cons:** invalid diagnoses and screening instruments; drug companies attempt to increase market share for psychiatric drugs

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## Part D

### Psychotropic Medications and Children: “First Do No Harm”



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“Children and adolescents are deemed vulnerable populations, at risk of being harmed by unethical or suboptimal practice and research and are in need of protection.”



(Spetie & Arnold, 2007, p. 15)

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### Medications have socio-cultural implications and impact children's identities



(Dell et al, 2008; Floersch, 2003)

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### How do children interpret their taking drugs?

To make sense of everyday medication treatment, children develop “illness narratives”

They may learn to see themselves as “defective” and unable to control their actions



(Dell et al 2008; Floersch, 2003)

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### Medication “messages”

*“Better living through chemistry”:*

Children learn to use drugs to deal with behavioral, emotional, academic and social difficulties



(Dell et al 2008; Floersch, 2003; Jacobs, 2006)

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Competent practice involves listening and responding to how youths make sense of their medication experience

This requires therapeutic and personal interpretation

(Dell et al 2008; Floersch, 2003; Rappaport & Chubinsky, 2000) 61

In child and adolescent psychiatry, medication decisions are infrequently guided by scientific knowledge, as data on safety and efficacy for most psychotropics in youths remains limited

(Jensen et al., 1999; Matsui et al. 2003; Spetie & Arnold, 2007; Vitiello, 2003)



*“The bottom line is that the use of psychiatric medications far exceeds the evidence of safety and effectiveness”*

Ronald Brown, Chair,  
2006 American Psychological Association (APA)  
Working Group on Psychoactive Medications for  
Children and Adolescents

St. Petersburg  
**Times**  
(2007)

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*“Whether one subscribes to the Hippocratic dictum ‘first, do no harm’ or takes a risk-benefit approach to treatment, it is impossible to discount possible unwanted treatment effects.”*



(APA Working Group on Psychoactive Medications for Children and Adolescents, 2006, p. 27)

## Part E

# Conclusions and Recommendations

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Non-medical professionals may neither prescribe, dispense, or administer drugs, but they may discuss any medication-related issue with their clients, including how their clients can attain their goals with the use or non-use of medications

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## Legal implications

Even professionals who do not prescribe are being called to testify in court about matters that directly concern treatment of clients with psychotropic medications

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## Training for competence

To remain competent in this emerging field requires basic education and training, including critical perspectives on drug use and marketing

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Professionals working with children receiving psychotropic drugs must take responsibility for their education, and be accountable to clients and society for *their own decisions* about medication-related issues

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## Ethical standards

A practitioner's involvement in referring children for medication, encouraging medication compliance, and monitoring effects, must rest on the *highest* ethical standards

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Can anyone ethically reassure clients about the safety of psychiatric drugs for children when information is not yet available?

(Littrell, 2003)

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## Balancing risks and benefits

When considering treatments, practitioners have an *ethical responsibility* to balance potential benefits with potential risks *and* to discuss both with parents as well as older children to *obtain informed consent from both*

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*“The potential for benefit from these medications must be balanced against the risks of not only the physical side effects, but also the social stigma, cost, inconvenience, and even family disapproval that can accompany even the most seemingly clear-cut, evidence-based treatment recommendation.”*

(Dell et al., 2008, p. 99)

**Given all the known risks associated with psychotropic drugs, attempting psychosocial therapies to treat problems in children *prior to considering medication* is an *ethical priority***

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### **“First do no harm”**

Use of psychotropic medications that have been *reported to have serious adverse effects in children—including death—should be halted* until research demonstrates that both short- and long-term benefits outweigh the already known risks



### **Avoid psychotropic drug use in young children until**

- ✓ evidence-based psychosocial interventions have been exhausted
- ✓ rationally-anticipated benefits outweigh the likelihood of risks
- ✓ parents/guardians are fully informed
- ✓ close monitoring is in place

(Vitiello, 2001)

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**Module 6**

**The End**

