UNC-CH School of Social Work Clinical Lecture Series

presents

Psychopharmacology and The Ethics of Forced Treatment

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Objectives

- Understand why non-prescribing therapists should also be familiar with psychopharmacology
- Understand some basic aspects of psychopharmacology
- Understand the ethics of forced treatment
- Understand issues related to forced medications

What we won't get to do

Discuss big pharma

Discuss the *idea* of drug treatment for mental illness

All apologies to Matt Goldenberg, MD

Case # 1: The Tremulous Trucker

- 35yo male truck driver
- Sees social worker for help w/marital stress
- Recent dx w/Hypertension
- Hx Bipolar Disorder
- New difficulty w/fine motor coordination, tremor

Picture from Photosearch.com

Case #2: The Wobbly Widow

- 83yo woman
- Seeing social worker b/c of sadness following death of husband, recent decline in function after hip fracture
- Recently restarted antidepressant that worked in past
- Becomes light-headed and nearly falls down after getting up at end of session

Picture from Photosearch.com

Case #3: The Panicked Painter

- 27yo woman, artist
- Recent onset of panic symptoms, agoraphobia
- Sees social worker for CBT
- Also taking medication rx'd by PCP
- Complains of new problems in relationship w/partner

Case #4: The Stiff Student

- 25yo man recently discharged from inpatient psychiatric unit
- Diagnosis: schizophrenia, ankle fracture
- He and parents here for family psychoeducation
- Has difficulty using crutches, moves slowly, blunted affect

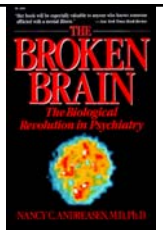
Picture from Photosearch.com

Lecture Objectives

- Prevalence of mental illness and psychotropic meds
- Basic classes, names and uses of psychotropics
- Common adverse effects to watch for
- Ethical consideration of treatment involving psychotropics

Lecture Outline

- History
- Epidemiology
- Pharmacology Overview
- Classes of Medications - Uses and Adverse Effects
- Special issues for social workers and psychologists



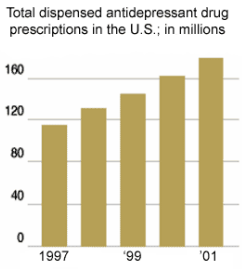
The Broken Brain:
The Biological Revolution in Psychiatry

History of Psychopharmacology

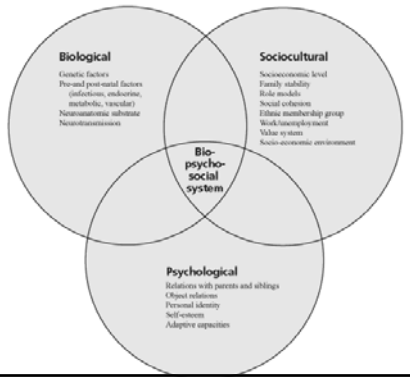
- 1949: Lithium
- 1952: Chlorpromazine
- 1950s: TCAs
- 1988: Prozac

Epidemiology

- Mental Illness large source of disability
- 10% women, 4% men on antidepressants
- Use 3x rate in 1988

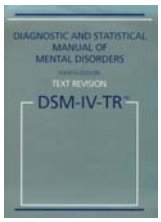


Bio-Psycho-Social Model



Psychiatry: Syndromal Medicine

- Mood disorders
- Anxiety disorders
- Psychotic disorders
- Cognitive disorders
- Substance Use disorders
- Personality disorders



Current Psychopharmacology: Limitations

- Lack of complexity: Depression is not simply a Prozac deficiency
- Lack of selectivity: Often leads to adverse effects

Choosing an Antidepressant

- Equal efficacy
- Prior treatment
- Family history
- Cost
- Potency
- Side effect profile
  - Sedation, e.g.
  - Drug interactions
  - Toxicity in overdose
  - Individual tolerance
- Physician familiarity

Antidepressant Medications

- SSRIs
  - Fluoxetine (Prozac)
  - Citalopram (Celexa)
  - Sertraline (Zoloft)
  - Fluvoxamine (Luvox)
  - Paroxetine (Paxil)
  - Escitalopram (Lexapro)
- SNRIs
  - Venlafaxine (Effexor)
  - Duloxetine (Cymbalta)

Common Adverse Effects of SSRIs

- Sexual dysfunction: very common, but often not discussed
- Nausea/GI
- Headaches
- Suicidal behavior (?)
- Hyponatremia

Antidepressant Medications (cont.)

- Mirtazapine (Remeron)
  - Sedation, Weight gain
- Bupropion (Wellbutrin)
  - Smoking cessation, less sexual SEs, anxiogenic
- Nefazodone (Serzone)
  - Liver toxicity
- Trazodone (Desyrel)
  - Sleep, priapism

Older Antidepressants

- Tricyclics (TCAs)
  - Amitriptyline (Elavil), Nortriptyline (Pamelor), Imipramine (Tofranil), Desipramine (Norpramin), Doxepin (Sinequan)
- CAUTION:
  - Dangerous in overdose (arrhythmia)
  - Anticholinergic
  - Orthostatic hypotension
  - Falls

Older Antidepressants

- MAOIs
  - Tranylcypromine (Parnate), Phenylzine (Nardil), Selegiline (Emsam)

- CAUTION: diet (tyramine free), serotonin syndrome (hypertensive crisis)

Anti-Mania/Mood Stabilizers

- Lithium
- Atypical Antipsychotics
- Anticonvulsants:
- Valproate (Depakote)
  - Wt gain, teratogenic, liver
- Carbamazepine (Tegretol)
  - Drug interactions (!), blood dyscrasia
- Lamotrigine (Lamictal)
  - rash

Lithium

- GOOD
  - Effective, proven
  - Works in all stages
- BAD
  - Narrow therapeutic window
  - Tremor, diarrhea, “fuzzy”
- UGLY
  - Quite dangerous at high levels
  - Renal failure, coma, death

Antipsychotic Medication

- Tried and true
  - Haloperidol (Haldol)
  - Chlorpromazine (Thorazine)
  - Perphenazine (Trilafon)
- Adverse Effects
  - EPS: acute dystonia, PD-like sx, akithesia
  - Tardive Dyskinesia
  - Extrapyramidal Side Effects
  - EKG changes
- EPS tx: benztropine, diphenhydramine

Antipsychotic Medication

- "Atypicals"
  - Clozapine (Clozaril)
  - Risperidone (Risperdal)
  - Olanzapine (Zyprexa)
  - Quetiapine (Seroquel)
  - Ziprasidone (Geodon)
  - Aripiprazole (Abilify)
- Adverse effects
  - Weight gain, DM
  - Some EPS (esp Risperdal)
  - Sedation
  - Expensive
  - Clozapine-- agranulocytosis

Huge market share, but not shown to be significantly more efficacious or safe than older drugs.

Anxiolytics

- SSRIs, SNRIs
- Buspirone (Buspar)
- Benzodiazepines
  - Diazepam (Valium)
  - Clonazepam (Klonopin)
  - Lorazepam (Ativan)
  - Alprazolam (Xanax)
  - Adverse effects: sedation, falls, delirium, DEPENDENCY

Dementia Medications

- Acetylcholinesterase Inhibitors
  - Donepezil (Aricept)
  - Rivastigmine (Exelon)
  - Galantamine (Reminyl)
  - Tacrine
- Memantine (Namenda)
- Side Effects: nausea, diarrhea, insomnia, urinary incontinence

Psychostimulants

- Used for ADHD, anergic depression
- Methylphenidate (Ritalin, Concerta)
- Dextroamphetamine (Dexedrine, Adderall)
- Nonstimulant: Atomoxetine (Strattera)
- Side effects: abuse potential, decreased appetite/growth retardation, insomnia

Alcohol Dependence

- Disulfiram (Antabuse)
  - Get sick if you drink
- Naltrexone
  - Blocks reward pathway
- Acamprosate (Campral)

Summary

- Patients on psychotropic meds are common
- Medications are often quite helpful, but can have adverse effects
- As social workers, you may be first to notice problems
- Questions?

Ethics

Three Paradigms

- Punishment—Law Enforcement
- Protect/control—General Public
- Treatment--Psychiatry

Is Forced Treatment *EVER* Justified?

A 47-year-old male who you admitted for elective colon surgery is found wandering the halls naked and bleeding from a detached IV site on post-op day 3.

He is "wild eyed" and mumbles or yells responses that are incoherent.

He appears to be looking for an exit and stumbles towards the fire stairs.

?

Decision Making Capacity

- Able to make a decision
- Understanding
- Appreciation
- Voluntariness
- Consistency

Approaches

- Principlism
- Deontology
- Casuistry
- Consequentialism

Autonomy vs. Beneficence

Paternalism

A dirty word?

Paternalism 1:
A believes that her action benefits S

Paternalism 2:
A recognizes (or should recognize that her action is the *kind of action* that needs moral justification

Paternalism 3:
A does NOT believe that her action has S's past, present or immediately forthcoming consent

Paternalism 4:
A regard S as believing she (S) can make her own decision on this matter

Moral justification - violating a moral rule

Morally Relevant Harms

- Death
- Disability
- Pain
- Loss of freedom
- Loss of pleasure

Causing these requires justification

Desiring these without an adequate reason implies irrationality

Morally Relevant Features

- What rule would be violated?
- What harms are avoided, prevented, caused? (foreseeable consequences)
- What relevant beliefs does the person hold?
- Does one have a duty to the person that sometimes would require a violation of a moral rule?
- Are there alternative actions that would be preferable?
- Is this an emergency situation?

A 43-year-old woman admitted for GI bleed refuses blood transfusion on the basis of her faith as a Jehovah's Witness

Justifying Paternalism

- "Just the facts ma'am" The "medical end run"
- It's only a matter of time
- The art of persuasion - eliciting patient cooperation
- Allowing this *kind* of action to be known and done in similar circumstances
- Does the harm avoided or prevented by this type of violation being publicly allowed *outweigh* the harm that would be caused by it being publicly allowed?

Publicly Acknowledged Balance

A 75-year-old man admitted for cardiac problems wants to leave the hospital against advise.

He says he must get home "to work in my shed."

His condition is serious and death without treatment is a real possibility.

The Decision to Force

- Benefit to patient more…
- …than combination of *risk of treatment* AND *harm of forcing*

Forced Medications

Treatment Paradigm

Rights-Driven Paradigm

Appelbaum, PS. The Right to Refuse Treatment… Am J Psychiatry. 145:4: 413-419, 1988.

What we do…

- Must be IVC'd
- Psychiatrist decides medicine necessary for patient to get well
- Treatment team meets
- Second opinion sought
- If all agree, non emergency forced med orders put in place

Capacity ≠ Competency

- Clinical judgment
- Can be assessed by any physician
- Usually question-specific, time-specific, short-term
- Surrogate decision-makers, if necessary

- Legal concept
- Can only be adjudicated by a court
- Usually more global, long-term
- Designated decision-makers

Exceptions to Informed Consent Doctrine

1. Emergencies
2. Incompetent patient
3. Waiver of informed consent
4. Therapeutic privilege

Conceptualizing Capacity

Patient's Decision → ↓ Risk/Benefit Ratio	Consent	Refuse
Favorable	**Low threshold for capacity**	**High threshold for capacity**
Unfavorable	**High threshold for capacity**	**Low threshold for capacity**